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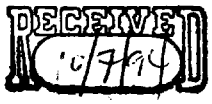

CS VIII

CARE BANGLADESH

MID-TERM EVALUATION REPORT

CHILD HEALTH INITIATIVES FOR LASTING DEVELOPMENT PROJECT

March 20 - April 15, 1994

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A . I . D .

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ACRONYMS

AHI	Assistant Health Inspector (MOHFW)
BRDB	Bangladesh Rural Development Board
CDD	Control of Diarrhea1 Disease
CHILD	Child Health Initiative for Lasting Development
c s	Civil Surgeon (MOHFW)
c u	Coordination Unit (CARE Bangladesh)
CWFP	Concern Women for Family Planning
DD-FP	Deputy Director Family-Planning (MOHFW)
DIP	Detailed Implementation of Plan
DG	Director General
EPI	Expanded Programme on Immunization
FE	Field Extensionist (CHILD staff)
FP	Family Planning
FPI	Family Planning Inspector
FT	Field Trainer (CHILD staff)
FW	Field Worker
FWA	Family Welfare Assistant (MOHFW)
FWC	Family Welfare Center
FWV	Family Welfare Visitor (MOHFW)
GOB	Government of Bangladesh
HA	Health Assistant (MOHFW)
HI	Health Inspector (MOHFW)
HIS	Health Information System of CHILD Project
HKI	Helen Keller International
ICDDR,B	International Center for Diarrhoeal Disease Research, Bangladesh
IPC	Interpersonal Communications
K&P	Knowledge and Practice Survey
MCH	Maternal and Child Health
MIS	Management Information System (MOHFW)
MOHFW	Ministry of Health and Family Welfare
NCDDP	National Control of Diarrhea1 Diseases Program
NGO	Non Government Organization
OR	Outreach Site
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO/CSSP	Private Voluntary Organization/Child Survival Support Program
SC	Satellite Clinic
SI	Sanitary Inspector (MOHFW)
THFPO	Thana Health and Family Planning Officer (MOHFW)

TFPO	Thana Family Planning Officer (MOHFW)
TICA	Training Immunizers in the Community Approach (CARE project)
TO-HIS	Technical Officer for HIS. (CHILD staff)
Tr. 0	Training Officer. (CHILD staff)
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VAC	Vitamin A Capsules

Other Information

Dhaka : Capital of Bangladesh

Chittagong : One of the five divisions in Bangladesh. (The others are Dhaka, Khulna, Barisal and Rajshahi)

Sylhet District : One of the 15 administrative districts in Chittagong Division.

Administrative units :

Thana	Administrative unit serving a population of 200,000; 11 Thanas in Sylhet District.
Union	Administrative unit serving a population of 20,000; 141 unions in Sylhet District.
Ward	Subdivision of a union (3 wards per union) with 6-7000 pop.; 423 wards in Sylhet District.

EXECUTIVE SUMMARY

The Child Health Initiatives for Lasting Development (CHILD) project provides child survival interventions [Expanded Programme on Immunization (EPI), Control of Diarrhea1 Disease (CDD), Vitamin A, Family Planning (FP)] to mothers and children through the strategy of managerial and work-style changes to improve existing government health delivery systems. Activities are focussed on strengthening service delivery in the Ministry of Health and Family Welfare (MOHFW) at all levels from the District on downward through the service delivery chain. This project is also an extremely important conduit for getting national-level strategies communicated out to the field and mobilizing implementation.

The CHILD project has been operating for 30 months. Activities have been implemented in a phased-in fashion because of the project design. The nucleus of the project is on the GOB's strategy of combined service delivery to deliver EPI and other Maternal-Child Health (MCH) services at the community level. Most efforts have been expended on strengthening EPI services for the longest part of the project as this responded to perceived needs of the GOB managers and was also important for demonstrating to them their ability to configure systems to improve service delivery and increase coverage.

The evaluation was conducted over a 4-week period with two external consultants and relied primarily on document review, a one-week period spent in Sylhet District, and qualitative data collection (key informant interviews with various levels of counterparts, CARE staff, and community members, visits to various activity sites). This information was supplemented by data from the 3 mothers' Knowledge and Practice (K&P) surveys (baseline and two annual surveys) and service and social mobilization measurements collected through CARE's Health Information System (HIS).

- **CARE is the one of the very few NGOs working with the MOHFW in an implementational project through a partnering relationship to improve the existing health systems. This presents the opportunity to build sustainability activities into project and observe progress as it occurs. Regularizing outreach services is the major project accomplishment in everyone's view.**

- **While too early for conclusions, there is anecdotal evidence of improvements in delivery systems :**

  workers doing a better job and spending more time working.

  women moving out of *baris* (house compounds) more easily to come to

services, women asking more questions of workers, women being more "open".

CARE female staff as role models for women (working, riding motorcycles).

workers just being visible in the community regularly may be contributing to women moving out of *bar-is.*

CHILD should continue project activities but refocus and streamline some areas. CHILD should negotiate phase-out activities individually by work area. (See section 9.b for specifics.) The social mobilization component should be carefully reconsidered and refocused on specific activities to strengthen field workers' abilities to be sensitive to and meet women's perceived needs. (See section 9.c for details.)

CARE should document and disseminate what CHILD and the MOHFW are doing in systems improvement/management strengthening.

In the long term, CARE should seek funding to extend the CHILD project for an additional 4 years. CHILD should continue the project in the original 5 area for the first year while expanding into the other 6 areas with a different methodology.

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Appendix

1. Introduction and Background

The Child Health Initiatives for Lasting Development (CHILD) project provides child survival interventions [Expanded Programme on Immunization (EPI), Control of Diarrhea1 Disease (CDD), Vitamin A, Family Planning (FP)] to mothers and children through the strategy of managerial and work-style changes to improve existing government health delivery systems. CARE has focussed its project activities on strengthening service delivery in a system which is heavily oriented towards government-supplied services. It works in the Sylhet District through the Government of Bangladesh's (GOB) Ministry of Health and Family Welfare (MOHFW) at all levels from the District on downward through the service delivery chain. Institutionalizing activities to regularize services has been the hallmark of this effort and has provided a mechanism for the district-level managers to improve services and monitor this improvement. This project is also an extremely important conduit for getting national-level strategies communicated out to the field and mobilizing implementation.

The CHILD project has been operating for 30 months; the first 12 months were a pilot project under CS VII to assess the feasibility and scope of the activities followed by 18 months of the present 3-year funding (CS VIII). After the pilot phase of activities in 5 of the 11 thanas (administrative units) of the Sylhet District, CARE had planned to expand activities to all 11 thanas. However, funding restrictions made this impossible and thus project activities have focused on the original 5 thanas.

The pilot year of the project centered on actively orienting district and thana managers to CARE and child survival strategies. While the project was designed with several child survival components,the activities have been implemented in a phased-in fashion because of the project design. The nucleus of the project is on the GOB's strategy of combined service delivery to deliver EPI and other Maternal-Child Health (MCH) services through community outreach sessions and satellite clinics'. Strengthening of EPI services is the activity on which most efforts have been expended for the longest part of the project as this responded to perceived needs of the GOB managers and was also important for demonstrating to them their ability to configure systems to improve service delivery and increase coverage.

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1 Community outreach sessions (OR) arc service delivery sessions held at a community household on a regular basis (usually once per month) to deliver services such as EPI, Vitamin A, snd ORS to community members. Satellite clinics (SC) are also held in a community household on a regular basii to provide family planning methods (including IUD insertion and injectable contraceptives) and antenatal and postnatal check-ups. Merged sites are those locations where both the OR and SC have been scheduled to occur on the same day at the same location, in hopes of providing women and children with a broader range of services

The evaluation was conducted over a 4-week period with two external consultants, an expatriate team leader with background and experience in child survival, and a Bangladeshi social scientist with extensive field and community-based research credentials. The evaluation relied primarily on document review, a one-week period spent in Sylhet District, and qualitative data collection (key informant interviews with various levels of counterparts, CARE staff, and community members, visits to various activity sites). This information was supplemented by data from the 3 mothers' Knowledge and Practice (K&P) surveys (baseline and two annual surveys) and service and social mobilization measurements collected through CARE's Health Information System (HIS). The cost of the evaluation was $ 15,006.

2. Accomplishments

Because the project operates in a partner relationship with GOB counterparts, a manner very different from the usual health services delivery project, some of the traditional input and output measures do not tell the whole story of what CHILD has accomplished thus far. In addition to showing that there have been increases in EPI coverage, for example, systems-improvement accomplishments of the project are extremely important as the activities become institutionalized. Review of inputs, outputs and outcomes are separated into two areas: technical and systems improvement.

Inputs: Technical

- CHILD Field Trainers (FT) have facilitated 79 MOHFW supervisory training/coordination meetings for EPI, 128 for Vitamin A, 105 for CDD, and 155 for FP.
- Field Extensionsts (FE) have assisted in 659 sessions for HA/FWA refresher training for EPI, 211 sessions on Vitamin A, and 166 sessions on ORT.
- FTs have held 172 EPI planning/performance review sessions with the EPI Technician and have conducted 329 sessions for cold-chain monitoring.
- FTs/FEs made 1498 visits with supervisors to outreach sites, and 376 to satellite clinics.

- FTs/FEs organized 21 MCH Committee meetings, facilitated 82 Union FP Coordinating Committee meetings and 82 FP review sessions at the FWC[2].

- In 1993, FEs made 302 joint visits with HAs for EPI registration. FEs made 319 joint visits with FWAs on household visits to support FP motivation and acceptance.

Outputs: Technical

- In 1992, 392 field workers received EPI refresher training, 357 on Vitamin A, 371 on CDD topics, and 374 on FP. In 1993, 1,219 worker-days were spent in refresher training on EPI, 1,737 on Vitamin A, 1,362 on CDD topics, and 888 on FP[3].

- 4 FTs and all 11 FEs have received training on FP methods.

- As shown in the table below, various community groups were educated on child survival messages in a variety of ways.

COMMUNITY MEMBERS EDUCATED ON CHILD SURVIVAL MESSAGES: 2-YEAR TOTALS

	EPI	Vit A	ORT	FP
Community women	-12,739	10,670	7,120	4,759
BRDB women leaders	339	406	359	236
Household owners (outreach sites)	984	956	467	120
Teachers	1,437	890	581	not applicable
School students	4,791	4,597	5,257	not applicable

2 The latter hvo are new activities since July 1992.

3 Data cannot be compiled across the project years because the system of reading and reporting this information was changed after the First Annual Report was submitted.

Outcomes: Technical

- **Direct (in the 5 project thanas)**
  - **From the yearly K&P surveys of children 12-23 months old and their mothers, conducted by CARE to document project progress (baseline, 10/91, compared with mid-term, 1/94, results) :**

    Increase in fully-immunized children 12-23 months from 6% to 34.6% (by card review only).

    Increased use of a contraceptive method from 10% to 22.5% in the proportion of mothers desiring no more children in the next 2 years.

    Increase from 34.8% to 51% the number of children aged O-23 months who received Vitamin A supplements in the past 6 months.

    The drop-out rate for DPT1-DPT3 decreased from 52.4% to 20% and for DPTI-Measles from 52% to 14%.

    The percent of mother stating that their children were immunized increased from 34% to 66.9%.

    The immunization card retention rate increased from 21.2% to 42.7%.

  - **In the 2-year period ending December 1993, MOHFW statistics' for the 5 thanas in which CARE is working show that more than 60,700 under-ones have received BCG and more than 60,300 the third dose of DPT. Over 52,000 under-ones have received measles vaccination. More than 10,580 pregnant women received at least 1 dose of TT and 16,606 pregnant women received their second or succeeding doses of TT.**

[4] These are reported MOHFW service delivery figures and not coverage statistics. However, they are used to illustrate the range of the target population being reached in various ways through the CHILD Project. In addition, because strengthening all aspects of services delivery including reporting and recording is a major part of this project, CHILD is phasing in more use of MOHFW statistics.

- **indirect (district-wide activities): CARE's support to district-wide Vitamin A distribution activities for children aged 1-6 (semi-annual distribution at the household-level) assisted the district to reach over 200,000 in 1992, and over 230,000 children in 1993 (a total of 435,737 children in the past two years), reaching almost all l-6 year-olds in the District with Vitamin A supplementation[5].**

Inputs: Systems improvement

- **Improving service delivery :**

  Facilitation to MOHFW for filling and assisting with training of 162 field worker vacancies.

  Service delivery planning, e.g. regularization of 6-month advance planning for outreach and satellite clinic sites and establishment of a fixed-date system for site scheduling.

  Assisting HA/FWA with semi-annual Vitamin A distribution activities including district- and thana-level planning, assistance in recording and reporting during household distribution, and post-round assessment.

- **Focusing service delivery :**

  Assisting the thana managers with merging of outreach and satellite clinic sites into the same location on the same day.

Outputs: Systems Improvement

- **Improving service delivery :**

  Seventy-five percent of planned outreach sessions for EPI and other interventions were actually held in 1993, from the baseline of 63% in 1991.
  72% of satellite clinic sessions planned for 1993 were actually held (increased from 10% of satellite clinics operational in 1991).

- **Focusing service delivery:**

  Over 50% of outreach and satellite clinic sites have been merged.

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5 Reported MOHFW statistics

Outcomes: Systems Improvement

- **39.5-41.5% of all outreach sites held in CHILD thanas were jointly attended by the HA and FWA as opposed to non-CHILD areas where joint attendance ranged from 19-23.5%[6].**

- **Success in regularizing cold-chain monitoring activities has led the Civil Surgeon at the district level to extend the use of the jointly-developed and implemented *Cold Chain Monitoring Checklist* to all thanas in the District.**

- **The DD-FP has incorporated the *Satellite Clinic Reporting Form* into the monthly meeting review sessions to clarify and extend the information reported in the MOHFW *FP and MCH Reporting Form.***

- **Thana managers have adapted an outreach session monitoring form and are using it as a standard *Supervisory Checklist for Outreach Sessions.***

The table in Appendix A summarizes the achievements by child survival indicators of the CHILD project as of January 1994, comparing the baseline and gains made to the final targets. (See detailed review in section 4.) It should be noted that the indicators for the final goals and the data collection methods available were not always compatible. Detailed discussion of these are in section 6.

Because the focus of the project is on improvement of existing MOHFW service delivery systems rather than direct delivery by CARE, the CHILD project reaches the target groups in different ways through the various interventions. The table below is illustrative of the ways in which CARE is reaching the intended beneficiaries. For example, based on the mid-term survey results from January 1994, CHILD exceeded its 1993 target of 30% of children under one to be fully immunized and is very close to reaching its 1994 target already. It also exceeded its end-of-project target for the under-one age group of reaching 50% VAC coverage while covering 84% of 12-23 month-olds targeted. And, while TT2+ coverage for pregnant women (the target group) is low (14%), the project has still reached 60% of the target population for 1993.

[6] MOHFW statistics for Sylhet District for August-October 1993

ILLUSTRATIVE EXAMPLES OF WAYS IN WHICH CHILD IS REACHING BENEFICIARIES

AGE RANGE	TOTAL POTENTIAL BENEFICIARIES[1]	EPI			VITAMIN A		
		FULLY IMMUNIZED 'TARGET 1993'	MID-TERM SURVEY RESULTS	% OF TARGET COVERED	TARGET 1994: 50%	MID-TERM SURVEY RESULTS	% OF TARGET COVERED
0-11	39,709				19,855	57.9% or 22,992	all-of-project target exceeded
12-23	39,709	11,913 30% of target group	34.6% or 13,739	1993 target exceeded and 86.5% of 1994 target already reached	19,855	42.1% or 16,718	84.2% of 1994 target reached
24-59	122,802				61,401	not available	not available
60-71	40,690				20,345		
WRA, 1549	245,114	12,256[*] 25% of target group	14.0% + or 6,863	60.0% of 1993 target reached			

[1] From DIP
[*] Pregnant women only, target = 49,022 for TT 2+
[+] Lack of vaccine supply for the first 4 months of 1993 along with TT card shortages and survey data showing that more than 70% of women said they never had a TT card make this coverage number extremely unreliable. It is used for illustrative purposes only

3. Relevance to Child Survival Problems

The major causes of childhood mortality in Bangladesh are shown in the table below. Morbidity from these same diseases is common. Additionally, Vitamin A deficiency is endemic both in Sylhet District and in Bangladesh, with nightblindness resulting.

CAUSES OF INFANT AND CHILD MORTALITY, BANGLADESH, 1991		
CAUSE	INFANT MORTALITY 110/1000 live births (1990)	CHILD (UNDER-5) MORTALITY 188/1000 live births (1991)
Low birthweight/prematurity	19%	11%
Tetanus	14%	8%
Measles	–	7%
Pertussis	–	2%
Diarrhea	16%	30%
ARI	23%	27%
Other	28%	15%
Source: UNICEF, Bangladesh Bureau of Statistics	14% preventable by immunization	17% preventable by immunization

Since the CHILD project works through existing government services, incorporation of the 4 child survival interventions has helped CARE respond to various GOB program demands. However, the implementation of activities in the 4 child survival interventions have occurred in a phased-in fashion. The 4 interventions also reflect the GOB's priority interventions and thus the project is able to respond to the community needs. The level of effort CARE had hoped to dedicate to each intervention is generally appropriate. There was a shift after the first year of the project away from a full nutritional intervention to focus on Vitamin A which is more appropriate, given the project design.

CHILD recognized that incorporating related social mobilization strategies were a necessary component to the innovative approach to combined service delivery. Thus, indicators measure both the effect of systems-strengthening activities to provide services at the community level (demand for services) as well as assessing mothers' knowledge about the child survival interventions. However, working within the GOB framework to reach community leaders, school teachers, students, and community women has focused project efforts in a way that has minimal impact at this stage. These strategies are discussed more fully in section 6.c.

4. Effectiveness

When evaluating a project which improves child survival through partnership with the service deliverer, indicators of organizational effectiveness must be considered along with those measuring technical achievements. There has been marked progress in regularizing outreach sessions, getting EPI and other services out to the community, as shown in section 2. Over 75% of planned sites were actually held in 1993. In the 3-month period, August-October 1993, 39.5-41.5% of all outreach sites held in CHILD thanas were jointly attended by the HA and FWA as opposed to non-CHILD areas where joint attendance ranged from 1 9-23.5%. This joint attendance is critical for combined service delivery since both workers register and motivate women and children during their household-visit schedule, and this registration information must be shared. The FWA is also then able to provide non-clinical FP methods and additional services. The merging of OR and SC sites brings even more of an opportunity for women to receive services.

The project has also made much progress towards achieving its child survival objective and the yearly targets. It is expected that the project will attain its final technical goals with some modification. Four intermediate goals are to be attained by June 1994, as shown below. (The end-of-project goals for 1995 are shown in parentheses for comparison.)

45% of children 12-23 months fully-immunized (end-of-project = 50%).

30% of women aged 15-45 protected with TT during their last pregnancy (end-of-project = 50%).

23% of mothers using a contraceptive method among mothers who desire no more children in the next two years (end-of-project = 20%).

55% of children less than 24 months with diarrhea in the past two weeks who were treated with ORT (end-of-project = 65%).

It is expected that the 45% coverage for fully-immunized children will be reached (from 34.6% in 1/94) as will use of contraception at 23% since the mid-term survey documented use at 22.5%. In addition, while no intermediate goal is set for Vitamin A coverage; the 1/94 survey showed that 51 % of children O-23 months received Vitamin A supplements in the previous 6 months which points to the project's ability to achieve CHILD's final target of 50% for 0-72 months.

Because CHILD works with the MOHFW through its existing service delivery system, progress on achieving two indicators, TT coverage and ORT use, have been directly affected by national-level MOHFW policies. The intervention that has been the most difficult to implement and at present the least successful is that of immunizing women with TT. Cultural considerations such as the difficulties for women to move outside of their homes along with superstitions and misinformation are exacerbated by national-level MOHFW redefinitions of the TT strategy over the past three years along with supply problems in TT delivery system'.

In addition, achievement of the desired targets for diarrhea management will be difficult since this has not been as readily seen as a perceived need by the MOHFW district and thana managers. CARE has documented that 69.8% of mothers reported giving children the same or more breastmilk during an episode of diarrhea, an indicator whose end-of-project target is 50%. However, it is not expected that June 1994 will see 55% of mothers interviewed stating that they treated their child with ORT for a diarrhea1 episode; the survey documented that only 35.8% of mothers had managed to do this.

Based on results from the Follow-Up Survey in November 1992, CHILD had expected to supplement the CDD systems-improvement efforts within the MOHFW by working with village doctors who are a main source of treatment that mothers use for diarrhea. However, policy and training curricula finalization have been slow in coming. It was noted by the project staff that they need to focus on CDD, and they have had active discussions with all levels of the GOB to identify an appropriate strategy to improve the use of ORT and increase food and fluid consumption during a diarrhea1 episode. Movement in this area should be progressing quickly now. The National Directorate for CDD has established an *ORT Corner* at the Thana Health Complex in at least 1 of the project thanas, and-they will be hiring a District CDD Coordinator within the next 2 months for Sylhet District.

Because the project works with the government to implement the GOB's child survival strategies, the project naturally addresses the needs of high-risk groups. Those who don't come to outreach sessions and satellite clinics for vaccination, Vitamin A, and family planning methods, for example, are identified through the field worker's household-visit schedule where dropouts and missed opportunities can be identified.

[7] notably a chronic shortage of cards until this year and a 4-month period of no TT vaccine Ltupply in early 1993.

5. Relevance to Development

The region constituting greater Sylhet is considered to be socially conservative, where popular religious interpretations are used to legitimize the subordination of women through the strict separation of public and private spaces. Women are discouraged from transgressing the boundaries of private space to a far greater degree than in the other regions of Bangladesh. Severe controls on women's mobility also limits women from actively seeking out health services either for themselves or for their children. This, coupled with the fact that a large proportion of males in the Sylhet region are working abroad, translates into even more restricted health care services for women and children. Hence, governmental health care provisions have been dependent, for the most part, on door-to-door services.

The CHILD project strategy has been to work through the existing MOHFW infrastructure to strengthen their capacity to deliver basic child and maternal health care services. The project itself works with the community to increase the abilities of families to participate and benefit from child survival activities through the social mobilization component of the project. The social mobilization strategy supports the systems-strengthening activities of the service delivery component and is targeted at getting women to move outside their homes to use health services. The project has ensured that governmental strategies to increase community participation and community demand for services are implemented more effectively. CHILD Project staff have ensured that appropriate planning of activities are conducted, schedules made and followed, regular community visits are organized, and health messages disseminated to mothers, both within the community as well as in the outreach sites. In addition, project workers assist in providing health messages to school students. Much of the CHILD staff's time each month is spent in the community; FEs spend 13 days each month in the field while FTs spend eleven days.

There have been some visible transformations taking place in the project area (and most likely in the greater Sylhet area) over the last few years, in terms of increased mobility of women. While the system of *purdah* still specifies boundaries of private space, women's intrusion into public space is increasingly acceptable where it is rationalized to be in the interests of family health. There is, therefore, increased communication with male health workers and indeed with outside males who are considered to be potential service providers. There is also an increased acceptance of women taking their children to the outreach sites and (to a lesser degree) to their going to the satellite clinics. While some of this mobility is due to changes taking place nationally, the project too has contributed to some of this transformation. Government and project field workers have, with their increased visibility, contributed to community women feeling more confident in interacting with the public and with outside males.

The regularity and reliability (quality) of services have also ensured that women come out and seek these services in the interests of their household health. Additionally, the presence of the CARE women workers on motorcycles serves as a role model contributing to breaking the strict barriers against women's mobility. Initially, some of these women were harassed but in time they have fast become an integral part of the Sylhet rural landscape. While community women are not copying this and riding motorbikes themselves, the presence of women in public and in such a "male" act as riding a motorbike is being considered acceptable. This allows for a re-evaluation of women's presence in public and acceptance of their visits to the OR/SCs. These changing norms regarding community women seeking health services are achievements that will be sustainable even if the project were to end. In fact, this dynamic of women's mobility has a strong demonstrative effect. Women who are still reticent to go to the health service centers will probably be persuaded to go to the health service centers just by observing other womendoing so.

An interesting feature of the Sylhet region is the presence of thousands of tea garden workers. These workers have traditionally not been ethnically Bengalis. They were brought in from other parts of India by the English to work in the tea gardens. The gardens were organized in a plantation system and the workers were no better than indentured slaves; women and young girls worked long hours picking tea leaves. Even now, though some changes have taken place, tea garden workers represent some of the most exploited sections of the population.

The project has assisted the MOHFW to provide services to the workers in several tea gardens in the project thanas. Ironically, the service delivery is easier here because of the strict authoritarian approach of the garden management - workers are told to receive these services. However, the living conditions of the workers (in urban slum-like situations) are probably responsible for a host of other health problems beyond the scope of the project.

6. Design and Implementation

a. Design

Two elements of the project design stage ensured that the design was appropriate to meet the objectives. The CHILD project represents CARE's analysis of the successes and changing GOB needs seen in the 7 years of their experience with

a CARE-Bangladesh immunization-based project' implemented in two of the five Divisions in Bangladesh as well as their realization in 1990-l that Sylhet District was an under-served area. From this experience highlighting the effectiveness of EPI through which managerial changes could be achieved to improve systems, CHILD adopted the strategy of partnering directly with the GOB health care delivery system.

Since most activities in health are decentralized to the District level, the project was originally planned to include all 11 thanas in the Sylhet District, but funding constraints forced CARE to reconsider expansion activities, continuing activities only in the original 5 thanas. Because of the administrative and managerial change process in the project's activities, the inability to focus on all 11 thanas has hampered activities such as district-level monthly meetings with thana managers to discuss EPI performance and problems. The non-project thana managers don't contribute to the discussions in the way CHILD staff had hoped, apparently because they don't feel that they have much ability to problem-solve for improvement. On the other hand, the district-downward focus has meant that CARE's assistance in planning, organizing and following-up of activities for the semi-annual Vitamin A household distribution rounds had effect across the non-project thanas in the district as well.

CARE has set measurable outputs and outcomes, but AID requirements for standardized child survival indicators and survey questions has made it difficult for CARE to demonstrate progress in some areas. As discussed above, there are difficulties collecting information about non-pregnant women vaccinated with TT. Also, the indicator for Vitamin A supplementation covers the age range of O-72 months. However, CARE's survey documents Vitamin A supplementation by age group for under-twos only (O-1 1 months, 12-23 months). Coverage of children older than 2 can only be inferred from the district-level MOHFW distribution statistics of capsules administered twice-yearly.

The original proposal included a large component to address changes in nutritional practices. That component was dropped in late 1992 after experience showed that CHILD could not be effective except through health education, a small part of CHILD's emphasis. A significant reason for dropping the nutritional component was the lack of clarity in the MOHFW about where responsibility lay for nutritional efforts at the community level along with CARE's lack of qualified staff for supporting the type of nutritional component originally envisioned. A major emphasis, however,

[8] Training Immunizers in the Community Approach (TICA) project has worked in the Khulna and Barisal Divisiona of Bangladesh since 1987. partnering with the MOHFW.

continued on Vitamin A-related activities*, both distribution and education, appropriate for Sylhet District where consumption of green leafy vegetables and other Vitamin A-rich foods is considered to be poor.

Redefinition of strategies in the project occur yearly when the experience of the year is reviewed based on the DIP and reviewer comments. For example, after the first year, reviewers suggested that the target for the objective for exclusive *breastfeedingpractice* be reduced to 20-30% from the 50% target shown in the D IP.

Additional project revisions have been made based on the results of the follow-up survey :

> A specific strategy to reach women working in the tea-garden plantations was developed since they had traditionally been under-served by the MOHFW structure".
>
> Informal linkages with village doctors have been made since they were highlighted in this survey as an important source of treatment mothers use when children have diarrhea. CARE field staff have identified the workers in their areas and facilitate visits with them and the MOHFW field workers during community visit days.

Activities in Family Planning begun since 1992 include attendance at and facilitation in the Union FP Coordinating Committee meetings which involves locally-elected officials for overall FP mobilization and to the FWC Review Meeting". Other changes in project strategies over the period included dropping regular meetings with women community leaders (the groups weren't cohesive and organized as they are in other parts of Bangladesh), and revising their HIS/monitoring systems (detailed in section 6. b).

The project has not been able to focus as much effort on CDD as it would like, in part because the national CDD strategy is only now being actively implemented. Thus, despite K&P survey results showing the importance of village doctors in treating children with diarrhea, CARE has not been able to move forward on a program to work

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9 15% of the grant is to be dedicated to Vitamin A activities.

10 CHILD has helped ensure that at least 1 merged session per month is held on a Friday (the weekly holiday day) per tea garden plantation.

11 A workshop in June 1992 critically reviewed the project's FP involvement which led to the addition of CHILD assistance to these areas.

with them for treatment of diarrhea-related morbidity. The survey has also identified fathers and siblings are child-caretakers leading the project to consider new social mobilization efforts such as the CHILD-TO-CHILD approach to reach these groups[12].

b. Management and Use of Data

CHILD has a full-time Technical Officer (TO) dedicated to HIS and monitoring and evaluation (M&E) activities. He is responsible for all aspects of routine monitoring and evaluation including development of M&E instruments, data processing and analysis, and follow-up of HIS implementation (quality control, development of and orientation to guidelines for HIS, etc). Half of his time is spent in Dhaka and 50% in Sylhet .

DATA USED FOR ORGANIZATIONAL REPORTING

CARE uses the annual surveys, routine HIS, and monthly compilation of field staff activities to track its progress against planned targets (CARE- and AID-based). Because of the amount of information required to meet external reporting requirements, a large amount of staff time at all levels is spent on data collection and assimilation activities.

CARE's HIS component of the project collects much information to track both the technical and the organization progress. The CARE field staff reporting requirements are extensive and document planned-vs-actual visits made and by status (single/joint), social mobilization efforts, and meetings. Reports are compiled, and these are used in the CHILD monthly staff meetings to review progress and highlight problems for discussion as well as for documenting quarterly progress for external reporting requirements. This information is also used in the CARE Annual Implementation Plan process, a critical review of every activity documented in the twice-yearly Project implementation Report. The next year's activities are then planned from this and field staff schedules are developed.

The routine HIS data is supplemented by yearly K&P surveys to assess progress towards the final goals. The baseline survey (10/91) in the 5 thanas was used to identify areas for intervention and provide a basis, after the pilot year, for comparison as project activities continued.

[12] The need for re-examining the CDD intervention is discussed in more detail in *Findings* and *Recommendations*.

DATA USED FOR SYSTEMS IMPROVEMENT ACTIVITIES WITH THE MOHFW

The monitoring system originally relied on several forms to collect data at the household and outreach and satellite clinic sites. An M&E workshop in 1 1/93 (with joint participation of CARE project staff and MOHFW counterparts) critically reviewed the data collection activities and the synthesis of the information. Revisions to the monitoring system have included dropping household data collection forms and the field-level EPI-based form[13]. In addition to forms used by CARE field staff for tracking work activities, several checklists assist CARE and the MOHFW to document and follow the progress of the project's efforts :

OUTREACH CENTRE MONITORING VISIT CHECKLIST
SATELLITE CLINIC MONITORING CHECKLIST
COLD-CHAIN MONITORING CHECKLIST

CARE has had success with using the HIS data for various purposes. Thana managers use EPI-based information for monthly discussions on EPI performance. The EPI technician uses the *Cold-Chain Monitoring Checklist* and the information on it is verified at 2 different sites each month by the CARE FT, documenting status of the vaccines and related supplies when they reach the outreach site. The usefulness of this checklist was validated through the use in the 5 thanas and the Civil Surgeon has now issued a district-wide order for this form to be used in all thanas[14].
It should be noted that the annual survey results, while shared with MOHFW counterparts, are not seen as useful by district and thana managers since the study population (mothers of under-twos) is too select a population to provide information useful to program managers[15].

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13 The data collection method produces a biased sample in the former and the latter parallels government records of numbers of doses delivered.

14 It should be noted that we were able to visit 1 non-CHILD thana during our field visit. Despite the rain which had forced cancellation of all outreach activities, we were able to meet with the EPI Technician to discuss how EPI is implemented there. He had never seen or heard of the checklist.

15 The survey would have been more relevant for managers if it had been able to include all 11 thanas so that service delivery and performance differences could have been examined. The potential differential effect of CARE's assistance in the district can only be indirectly assessed. It is impossible to determine, at this stage, for example, whether there is a differential effect in the CHILD-supported thanas or whether services arc available all over the district since moat staff vacancies in all project and non-project thanas have been filled. in addition, the facilitation efforts at district level to improve service delivery activities have spill-ova potential as non-project thana managers arc exposed to efforts at managerial change in monthly review meetings and through other mechanisms such as planning for Vitamin A distribution.

Institutionalizing the data analysis and synthesis efforts that CHILD has promoted have centered on preparation of EPI coverage graphs for the THFPO's office, charts in the control room for vaccine-delivery planning over the year, and preparation of charts on Vitamin A coverage and disease surveillance. As discussed above, the recognition for improved reporting and reporting has extended to adoption of new and revised forms. In addition to the *Cold-Chain Monitoring Checklist,* the *Satellite Clinic Reporting Form* developed by CHILD has been advanced by the DD-FP to Divisional and national levels, citing its usefulness as an adjunct to the *FP and MCH Reporting Form*[16].

Data collection to date has focussed on quantitative data and quantitative indicators to show target achievement. It is necessary for the project to engage in some qualitative investigation to determine both project impact as well as to develop strategies to better accomplish project goals. Qualitative research is required to determine:

- barriers to increased participation of community mothers.
- effectiveness of strategies such as CHILD-TO-CHILD.
- strategies to increase interpersonal communication between the field worker and the community.

While project staff may not have the necessary skill to undertake such research, much of this qualitative investigation need not be expensive.

CHILD shares information with counterparts at national level in various meetings and with other PVOs through the *PVO Forum,* a regular meeting of all PVOs working in child survival. Debriefings on the annual survey results have been held in both Sylhet with government counterparts and in Dhaka for national-level counterparts, donors, and other agencies. The survey reports are also distributed widely. The CHILD Project Coordinator had an article published in the HKI publication, *Vitamin A News Notes,* discussing CARE's progress with Vitamin A activities in the CHILD project. However, written documentation and formal dissemination about the project and what has been learned thus far has not yet been done.

[16] It shows the individual worker's work over the month rather than combining information from the FWV, WA. and TBA as the MOHFW form mandates.

C. Community Education and Social Promotion

Social mobilization (SM) refers to the act of increasing popular awareness for the purpose of increasing community demand for services. In the context of Bangladesh, SM has come to mean a one-sided barrage of information without considerations of community response. The dialogue that should characterize effective SM is generally absent. This leads to situations such as that where there is nearly universal knowledge of preparing ORS but actual use is low.

In CHILD, SM is based on providing health messages to community mothers during community visits as well as at the outreach sites. These messages are provided both individually as well as through group discussions. CHILD has also experimented with working through BRDB women's groups and through schools to increase the level of community awareness. Other than providing some assistance during National Immunization Week every year, CHILD is not involved in any massive campaigns.

The project strategy ensures a close integration of service provision and social mobilization within the broader strategic constraint of working through the MOHFW rather than directly with the community. At the thana level, this translates into FEs spending ten days with the field workers in community visits and three days in satellite clinics where service delivery is combined with health education. FTs spend three days doing community visits and eight days in outreach sites and merged sites.

Some health education is also offered through the primary schools. Health education under the CHILD project involves providing information on immunization, night blindness, diarrhoeal diseases, family planning as well as nutrition. The messages are specifically related to increasing community demand for governmental health care services in the form of immunization (EPI and TT), VAC, contraceptives, and in the control of diarrhoeal diseases.

Since CHILD is working within the governmental infrastructure, the health education messages that are disseminated are those that have been tested and developed at the national government level. The slogans, pictures, and flipcharts are all part of the governmental educational package that are used all over. CHILD ensures firstly that these materials are used, and secondly that the MOHFW field workers have the skills to use them appropriately.

CHILD has been actively trying to seek creative approaches to community education. It has successfully involved the house owner (the person who volunteers his house for the holding of the outreach site/satellite clinic) in advocating for health care services. Many house owners will go door-to-door informing the community of

the next outreach session. CHILD has also been actively considering introducing a CHILD-TO-CHILD strategy as well as mobilizing Imams (religious leaders) and village doctors in promoting greater health care awareness within the community.

The project has included the school program as part of its social mobilization strategy, based on lessons from the TICA project, and building on efforts by the GOB to include health education in the schools. Primary school students from several classes are brought together for a session on a health care topic provided either by the teacher or the MOHFW field worker. Currently, only one school is covered by each FE in every thana every month.

There are several problems with this program:

A significant proportion of children are not enrolled in school.

At the current rate of coverage, only two or three schools are covered each month in each thana implying an interval period of months between two sessions at each school.

Children learning about health care does not necessarily translate into mothers learning from them or seeking better health care services.

No follow-ups.

A major element of CHILD's social. mobilization strategy are the group meetings. These meetings do provide an opportunity for community women to receive health messages but are limited by their authoritarian and non-participatory approach. Field workers lecture while everyone sits in a semi-circle and listens to messages which emphasize memorizing names of diseases. Additionally, these meetings provide coverage to a small number of women. To reach more of the community women, CHILD should perhaps still depend on the door-to-door visits but concentrate on improving the quality of the interaction to ensure greater participation of mothers at the OR sites.

There exists an observable absence of effective communication skills both in government workers as well as in CHILD project staff. Since the program is extremely task-oriented and target-driven, field workers concentrate more on fulfilling targets. This makes their interaction with community women very mechanical. This is all the more tragic since socializing and visiting is so much a part of the Bangladesh cultural tradition. Instead of concentrating on building rapport with community women to make their messages more effective, field workers remain impersonal and focussed on

questions relating to contraceptive use or health. There needs to be a reorientation to make field workers treat community women more as people and less as clients, and there has been some recognition of this problem within the government and the project. The MOHFW has Interpersonal Communication Skills refresher training ongoing, and CHILD has started experimenting with participatory methods of community work. It is still too early to determine the effectiveness of such initiatives.

How far these health education strategies have contributed to an increasing community awareness of health issues is unclear, but the presence of the CARE worker in the field strongly seems to have ensured a more intensive and concerted community-based activity of the government field worker. This appears to have led to an increased women's attendance at the outreach sites and thus increased community coverage.

The community too identified an increase in field worker visits and regularity of services. While most community mothers do not make a distinction between government and CARE staff, they do look at CARE workers as health personnel coming in from the outside, and therefore more important and more credible than the "familiar" government field workers. This has lent legitimacy to the work of the government field workers and has contributed to increased community demand for services.

d. Human Resources for Child Survival

The CHILD project employs a staff of 30 and is run primarily from the CARE sub-office in Sylhet town. (See organizational chart, Appendix C.) Twenty-seven are based at the project site with all field workers resident in the thana headquarters town in which they work; three senior staff are based in Dhaka. There are 21 basic field workers, 10 Field Trainers (FT) and 11 Field Extensionists (FE), all multi-purpose workers applying an integrated approach. More than 50% of the staff are female, and all FEs (who make FP household visits) are female.

Two Assistant Project Officers (APO) provide support to field staff and are the immediate supervisors of the FTs and FEs. The Project Officer (PO) is in charge of District-based activities and supervision of the field staff (the 2nd level of supervision from the Sylhet office). The PO also has managerial responsibilities which include organizing monthly staff meetings, routine communications with staff, and compiling and analyzing the field reports.

Senior staff based in Sylhet include the Training Officer (TrO) and the Project Manager (PM). The TrO is a technically-qualified professional who ensures staff development in training methodologies as well as providing review of all training activities. The PM spends 50% of his time on technical responsibilities for appropriate project implementation. The other half of his duties are managerial: planning and oversight of supervisory activities, staff management, and other administrative, logistic and financial issues related to project implementation.

The full-time Technical Officer (TO) spends 50% of his time in Sylhet and 50% in Dhaka and, as described in section 6.b, he is responsible for all aspects of routine monitoring and evaluation activities.

Overall coordination and responsibility for financial and administrative management and technical implementation is provided from Dhaka by the Coordination Unit comprising the Project Coordinator (PC) and the Assistant Project Coordinator (APC).

The project does not use community volunteers for service delivery activities, but various community-based liaisons such as with community women leaders, school teachers, and owners of the households where the outreach sessions are being held have been educated on child survival topics in a strategy to support and expand the information delivered by field workers.

All but 4 staff members have been with the project from its inception. There are corresponding counterparts from the MOHFW at each level from the district on down to the field workers. Half of the project staff were recruited from another CARE health project and so were experienced in immunization strategies and health education efforts, and were familiar with the government health delivery system when CHILD began. The other half were newly-recruited from Sylhet District and speak the Sylheti dialect. All staff received a 30-day training at the start of the project and new staff were oriented to CHILD through a visit to that CARE health project prior to training.

The orientation at that project and the field exposure was an appropriate initial training design for the FTs and FEs since the design of the project included a plan for meeting ongoing refresher training needs. There is ongoing one-day training every month at the Sylhet sub-office. At these training sessions, training needs are determined through discussions with FTs and FEs who indicate their felt needs based on field experiences, as well as needs expressed by the MOHFW staff. In addition, the project Training Officer undertakes training needs assessments through field visits, field observations, and analysis of the training and evaluation checklist. The Project Manager, Project Officer, and the Training Officer together review these needs and

prioritize the training agenda. The one-day training sessions also include discussions on one or more of the seven topics (EPI, diarrhea, vitamin A, family planning methods, birth-spacing, tetanus, breastfeeding) for which CHILD has a well-developed curriculum.

e. Supplies and materials for Local Staff

As discussed above, CHILD is constrained by its use of MOHFW educational materials; in some cases, staff feel the messages aren't appropriate. They would like the option to use other materials to be able to improve their educational approaches to be more effective. Nevertheless, since CHILD's strategy is to work within the existing government systems, CHILD must continue to rely on the GOB-approved materials.

It was reported that, prior to CHILD, government workers would often arrive at the outreach sites or visit communities without their training materials or supplies. While this practice has declined, the fact that replacement supplies are often not provided from the MOHFW[17] has meant that EPI tablecloths are torn, flipcharts are damaged, etc.

f. Quality

CHILD tries to ensure that project staff receive adequate training. (See section 6.d.) In addition to the 30-day basic training (which combines classroom discussions with field visits) and the one-day/month ongoing training at the sub-office, CHILD staff also receive technical training on EPI and FP. A few workshops have been held with counterparts (AHI and FPI at the thana level based on field issues and MOHFW needs) as well as exclusively for project staff. Project staff workshops have included a monitoring and evaluation workshop and a joint retreat with CARE's NGO-SP project.

CHILD ensures staff quality through the training they provide and the ongoing evaluation and supervision they conduct. Training is evaluated through field visits and field observations of training officers, while supervisors (APO, PO and PM) ensure quality of the field performance.

Staff are also provided with opportunities to attend formal training workshops. Four FTs and eleven FEs have received three weeks of training in FP methods.

[17] There is a system for obtaining replacements for these items but there has been a logistic bottleneck which means that practically speaking, these items cannot be replaced.

However, they indicated to the evaluation team that they would prefer receiving some FP clinical training to prepare them better for assistance at the satellite clinics. All CHILD field staff cite the need for refresher training on EPI, especially clarification of vaccination strategies and injection techniques. While they have more than adequate understanding of the MOHFW and GOB systems, it is uncertain whether the project field workers have a clear view of the larger project context in which they play such an important role.

CARE also has a yearly process to assess staff performance and training needs. In addition, training needs are assessed after reviewing the AIP and the new activities contained within.

Individually, staff at all levels have participated in internal and external training opportunities. Twenty-five staff received 3 days of training on KAP methods by the external consultant for the baseline survey and 24 staff received 6 days of training on the HIS from. The PO and 1 FT attended a 10-day workshop on FP management issues, all 11 FEs and 4 FTs attended a 3-week FP methods workshop, the APC attended a l-week Nutrition workshop, and the TrO went to a 2-day CDD workshop over the period. The PM also attended a 6-day management training course at the Bangladesh Management Development Center. The APC and PM attended the 1993 Asia Regional PVO Child Survival workshop in Comilla (Bangladesh).The CHILD field and managerial staff feel that they have much of the training they need for their work. However, some field staff would like more training on injection techniques for EPI and all field staff feel they want more information on FP technical training. Managerial field staff would like additional training on supervision.

Field staff skills in counselling and health education (individual and group) were not able to be assessed well because not all field staff were observed and, of those observed, all visits were planned ahead of time. However, of those observed, the efforts at improving MOHFW field worker delivery of counselling and motivation messages were less than successful. As one manager described, the use by the field staff of participatory techniques such as sitting in a U-shape and using a flipchart have become translated into mandates. Workers now direct women how to sit, what to look at, and what to think, using an approach very similar to the approach used in many traditional school systems.

g. Supervision and Monitoring

A comprehensive and planned supervision and monitoring component was part of the original project and it has continued and is effective. Since the project staff reside and operate in the project area, there is active and regular supervision from the district level of the CARE field staff. Supervisory staff including the PM and PO make field visits to monitor field staff activities and provide on-the-job training for their staff to rectify any problems seen during the visit. The two CHILD APOs supervise FTs and FEs, reviewing their work plans and meeting with them frequently to assess their field activities. (See section 6.d.)

All field staff meet monthly for 2 days - one for administrative and management issues and one day for training. Technical topics are covered along with problem-solving sessions for specific field problems that have arisen. Documentation of the internal project control of field activities can be judged from the various supervisory checklists as well as field-level reporting formats developed for the project. In addition, project review meetings monthly at the Sylhet and Dhaka levels contribute to constant supervisory oversight and feedback mechanism. Finally, overall supervision is provided by the Coordination Unit in Dhaka (PC and APC) on global aspects of the project (implementation/financial/technical). It is expected that these supervisory oversight mechanisms will be adequate for the life of the project.

h. Use of Central Funding

The CHILD Project at CARE-Bangladesh coordinates with the Primary Health Care Unit (PHCU) at CARE Headquarteis in Atlanta for submission of reports to AID and to ensure the project's compliance with AID requirements for the grant. Channeling reports and communications in this way also provides the project with the PHCU's technical oversight and review. A Regional Technical Advisor (RTA) for Health, based in Nepal, provides technical assistance to all health care activities in the Asia Region and is available for consultation as needed. The PHCU assists in all aspects of proposal development, research and evaluation design, support on technical subjects, preparation of various planning/reporting documents, and workshops and seminars on special topics.

Because the project was staffed from inception with many staff experienced in a similar project and familiar with CARE, CHILD has not needed *extensive technical and administrative support from the RTA or the PHCU. Intermittent visits such as that of the Director of the PHCU in March, 1993, provide appropriate on-site project support to review the DIP, advise on technical inputs for the HIS redesign, etc.

An activity supported by the PHCU on behalf of the project was the 1992 Asia Regional PVO Child Survival workshop in India on KAP Survey Methodology organized by CARE PHCU and attended by the CHILD APC.

The support to CARE headquarters is integral to maintaining the timely and up-to-date technical support needed by health-related projects including CHILD. Since the nature of CHILD is more than just as a service provider project, the PHCU strengthens CHILD's ability to maintain a systems perspective to improve service delivery in an existing system. Because of their US location, the PHCU also is the communication channel for maintaining communication with the AID PVO office, and is an active conduit with JHU CSSP for clarifying AID guidelines and for ensuring that CHILD fulfills AID requirements.

i. PVO's Use of Technical Support

The project is headed by a long-term, expatriate Project Coordinator who has been with the project since the inception. She is a physician experienced in public health and residential experience in developing countries. The PC is responsible for overall project implementation as well as giving global direction to the project by facilitating and maintaining linkages with external networks. CARE-Bangladesh's expatriate Health and Population Sector Coordinator, an experienced professional with a background in international public health and experience with AID and AID-funded projects such as WASH, also provides ongoing technical and administrative support to the project. As the Sector Coordinator, she is responsible for ensuring coordination in the health sector strategy bringing the long-term vision and innovation to each of the health sector projects.

JHU CSSP provided a technical consultant for development and implementation of the baseline survey in late 1991. This consultant also trained all project staff in survey methods during that time. Two local consultants were used for the design and installation of the HIS in 1992.

Because the child survival strategies in this project are those of the GOB (reflecting GOB and donor collaboration for policy development), CHILD has needed little technical assistance beyond that for monitoring and evaluation activities. In addition, almost all the staff are Bangladeshi and many of the original staff had worked in a similar CARE project and were experienced in immunization and social mobilization activities in the government services as well as CARE's philosophies.

The CARE-Bangladesh Health Sector organized training on Participatory Rural Appraisal methods, using an external consultant. Four CHILD field staff participated

in this 10-day workshop. CHILD staff has also made cross-visits among the other health projects in CARE-Bangladesh to learn what other projects are doing and what could be applied within CHILD.

An unplanned but extremely useful visit to the project area in Sylhet and to the project office in Dhaka was made by Dr. Dory Storm in November, 1993, after her attendance at the 1993 CS Workshop. This offered project staff the opportunity to clarify CS grant issues that are somewhat different for CHILD because of the nature of the project.

Technical support was also provided by the CARE-Bangladesh mission resources. The PM attended a 3-day workshop on AIDS and the TrO a 6-day workshop on HIV/AIDS. The TrO, PO, and 2 APOs spent 10 days learning about Participatory Rural Appraisal (PRA), and the TrO and 1 FT received a 1 -day orientation on Participatory Extension Methods.

In the next 6 months, CHILD envisions procuring technical assistance for revising the social mobilization component of the project along with assistance for proposal development to continue activities in the Sylhet District. The consultancy for the latter would also provide expertise to the project on disseminating the systems-improvement activities which are improving delivery of the child survival interventions. Budgetary constraints, however, make it impossible for staff to envision being able to procure the kind of support desired.

j. Assessment of Counterpart Relationships

CHILD works with the government in building its capacity to deliver quality services, focusing is on transfer of skills and on-the-job training. CHILD emphasizes sustainability and hence the need to avoid dependence on CARE by developing and strengthening governmental institutions. This is where CARE's unique experience allows for the potential of sustainability after CARE withdrawal.

The chief counterpart organizations to CHILD are the Departments of Health and Family Planning under the government's MOHFW. At the district level, CHILD liaises with the Civil Surgeon (Health) and the Deputy Director of Family Planning. At the thana level, the executive officers are the Thana Health and Family Planning Officer (THFPO) and the Thana Family Planning Officer (TFPO).

At the district level CHILD is involved in the identification and discussions of local-level problems as well as the planning and management of field-level operations pertaining to EPI, FP, VAC and CDD. CHILD staff assist in developing the plans for

merging outreach sites and satellite clinics. They participate in the analysis of EPI performance and the review of logistics and assist in analyzing CDD field reports and ensuring ORS supply to the thanas.

At the thana level, CHILD assists in the planning and program monitoring of MOHFW managers and supervisors. Project staff assist in the holding of monthly meetings and the preparation of six-month advance schedules of supervisors and field workers. They collaborate in the EPI performance monitoring, cold-chain monitoring (the thermometer, the temperature, the ice packs, the quality and supply of vaccine, sterilization), diarrhoeal disease monitoring, and the distribution of VAC.

At the outreach sites, FTs participate with supervisors in ensuring that EPI outreach sessions are held at the designated sites (not door-to-door as was often the case previously), checking the registration book to confirm that it is updated and the field workers were in fact making community visits, check for on-the-spot sterilization, checking for the quality of injections, and providing health education. In like fashion, at the satellite clinics, FEs work with supervisors to ensure that the FWAs are supervised and health education provided.

In the community, project workers ensure that government workers do in fact make the community visits and interact with mothers, fill out their registration books clearly and correctly, and hold health education sessions through an examination of the registration book, tally sheet, and MOHFW *Monthly Reporting Form.* In addition, by being present at the some of the health education sessions, they assist the GOB field workers to ensure that health care messages are clear and understandable. Project workers also assist in the school health education sessions.

Project staff are also involved in the planning and execution of VAC rounds. Health workers have been trained to ensure that VAC are distributed individually to children (and not in bulk to older people) and, in the case of children under one year, drops are administered directly by FWs at the outreach site.

There are preliminary indications that thana managers and field workers are taking and, and will be ready to assume, some of the activities that CHILD staff have been maintaining. It is felt that within a year and a half (completion of current project phase), certain elements of CHILD's monitoring system such as the Reporting Forms discussed in section 6.b shall have been integrated within the normal functioning of the MOHFW at the thana level.

Specifically, CHILD staff believe that elements of the following management activities will be phased over to the MOHFW managers:

call the meeting, prepare the agenda and record resolutions (thana-level supervisory and monthly field worker meetings)

preparation of six-month advance schedules for outreach and satellite clinic sites

conducting union-level coordination meetings

temperature checklist, maintenance of the cold room, supplying vaccines to OR sites, planning and ordering appropriate vaccine supplies (cold-chain monitoring)

preparing and maintaining yearly dose-vs-target antigen graphs, completing registration books, and analyzing targets to identify low-performing areas (EPI performance monitoring and record-keeping)

Other elements of CHILD strategies (social mobilization, field-level supervision, outreach sites/satellite clinics) will probably continue but most likely at a far lower level of performance.

The nature of the project mandates open dialogue between CARE and its counterparts. After more than 2 years of working together, CHILD staff have excellent relationships with their counterparts at all levels from District on down. Senior staff note the gains made in communications with district and thana managers who feel free to contact them even on weekends or in the evenings to discuss activities and issues. Some GOB managers use CHILD staff for advice on handling problems as well.

Evidence of counterpart relationships is also demonstrated in the CHILD staff participation in various MOHFW workshops:

EPI cold chain maintenance	PM
National EPI Planning workshop	PM
EPI Findings and workplan review	PM, PO
Disease surveillance	PM

k. Referral relationships

There are no fixed referral facilities used in this project. However, there are crucial referral linkages that the project facilitates. During community visits, the FW refers mothers to outreach sites and satellite clinics for vaccination, antenatal/postnatal care, and clinical FP methods. The project will also strengthen the link between the community, the outreach sites, and the ORT Corner at Thana Health Complex as the national CDD strategy is formalized.

l. PVO/NGO networking

At national level, CHILD project staff meet frequently and regularly with both NGO and government representatives in various working committees for specific strategies" as well as the PVO Forum discussed above. Because of the large donor and PVO/NGO community and the large population to be covered, the specific strategies are usually quite vertical and specific in their approach, focusing on a single intervention. While the various committees and working groups keep communication open and fosters exchange of ideas, Dhaka-based staff prioritize their attendance at and participation in these working groups, meetings, and workshops as the numbers have proliferated. This strategy allows them to protect time needed for project management and field visits.

In addition to the lessons learned from the TICA project (see section 6.a), CARE has visited Save the Children-US project areas as SAVE has implemented their CHILD-TO-CHILD strategy and provided technical assistance on this. Discussions with World Vision about their experiences with the use of community volunteers led CARE to conclude that Sylhet was not an appropriate area for volunteers since people in Sylhet are relatively better off financially than many areas of Bangladesh and may not have an incentive to work.

At the beginning of the project, the senior project staff also had meetings with and made field visits to the ICDDR,B MCH-FP Extension Project to determine the applicability to CHILD of their operations research findings on working within the MOHFW system. CHILD adopted the strategy of the FWC review meetings from them.

[18] EPI National Steering Committee, EPI yearly National Planning Workshops (at all levels), CDD Communication Group, UC. To maximize resources and decrease duplication, a representative from a CARE FP-baud project attends the FP Cooperating Agency meetings.

m. Budget Management

Project spending of AID grant funds has been timely and generally according to the budget. Funding for the first year of the project (funded under CS-VII) was less than expected because the project was just starting. As described earlier in this report, the nature of the CHILD project resulted in the interventions being implemented in a phased-in manner and so not all activities were up and running immediately. Remaining funds could not be carried over after the contract end-date, but delayed clarification about these policies and final contract dates meant that the funds remained unspent.

Funding from CS-VIII for 3 years of activities began on September 1, 1992. However, because the AID grant amount was about one-third less than applied for, senior project staff have been exceedingly attentive to controlling expenses to ensure that the project funds are spent as proposed but still staying within the revised budget. Additional savings to the project have been realized by the senior project staff through regular interim budget reviews and revisions, both within the project and within the CARE-Bangladesh mission", and a flexible approach to project implementation to maximize use of available resources.

This has resulted in using GOB facilities for project activities[20], important for sustainability as well, and collaborating with another CARE-Bangladesh project to provide staff development training on FP. Activities for which consultant services were originally planned were able to be carried out without the external consultant[21] resulting in reallocation of those funds for other project activities. In 1993, the Personnel line item was somewhat underspent because the Cost-of-Living-Adjustment for Bangladesh was not as high as originally budgeted, because there were several person-months of staff vacancies, and because CHILD is now paying a smaller proportion of CARE-Bangladesh's shared direct costs for personnel.

The pipeline analysis is shown in Appendix H. Over the project period, spending has been at an average of $20,000 per month. The project is not likely to have

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19 CARE has extremely good financial systems worldwide and CARE-Bangladesh's Fiiial Office is no exception in providing budget and financial monitoring and administrative support external to project staff.

20 For example, the CARE field staff have an office within the Thana Health Complex building rather than needing to rent a separate oftia.

21 Plans for carrying out several special studies on FP were revised after several appropriate completed studies were identified and reviewed. Also, the plan to use a consultant to assist with the Novanber 1992 annual survey was changed and the survey was implemented without external technical assistance.

The pipeline analysis is shown in Appendix H. Over the project period, spending has been at an average of $20,000 per month. The project is not likely to have unspent funds at the end of this grant period. CHILD will be able to achieve its objectives with the funds that remain.

6. Sustainability

The nature of this project promotes sustainability as CARE is working in a partnering relationship with the government and CARE does not provide services directly. Improving health delivery and managerial systems to improve efficiency is critical to their being institutionalized.

As this project has demonstrated, the process of changes to, and improvements in, work patterns takes time. It took CHILD about one year just to build up their credibility in the Sylhet District and in the 5 project thanas since senior and mid-level managers had to be oriented to CARE as well as to the type of assistance CARE proposed to bring to them - transfer of technical skills rather than the more usual replacement workers for service delivery and/or supplies and equipment. In addition, at the time CARE proposed and began the pilot project (1990-l), the Sylhet District had extremely little contact with and exposure to any NGO activity and there was little donor interest in the area as well.

The design of the project is such that CARE field staff meet with same field worker only a few times each month. Perceptions of senior project staff are that, despite the relatively infrequent direct contact with CARE field staff, government field workers may become dependent on CARE. At this point in the project, there should not be undue concern about dependency by government staff. It must be remembered that the health delivery systems (specifically for EPI and Vitamin A distribution) are just now functioning more efficiently and demonstrating improvement in services. Government counterparts now are working more comfortably in areas where services are functioning better, and they will be able to separate out in the next year CARE's assistance to them from the efforts that they make themselves to improve services.

The project is quite well received by district and thana managers and field staff. Managers point with pride to EPI and Vitamin A coverage graphs and discuss improved coverage as well as reporting. GOB field staff feel that CHILD field staff *give them* support and *make them strong*[22]. All workers interviewed cite CARE's assistance in the community field visits as giving credibility to'worker messages.

[22] Direct translations from the worker interviews.

GOB FWs feel that they have been working so long in some places that the community people ignore them. They have found that, when they make their visits with CARE staff, community people are interested again in the motivational messages. One worker voiced his need for more CARE field staff so that he could call on their help at household visits on a day when he knew that he was going to visit a particularly difficult area which needed additional motivation.

Evidence of the work-style changes that CHILD has already assisted thana managers and field workers to make can be found in the following examples:

- At District-level meetings, supervisors are coming with problems and also suggestions for solving those problems: There had been difficulties getting the vaccine carrier sent out from the thana headquarters to the location of the OR session. Sometimes the designated porter did not report to work and then no vaccine was delivered. Thana managers identified this as a barrier to proper OR session functioning and the solution they developed and agreed upon was to no longer have a designated porter. The porter is now identified at the time the vaccine carrier needs to be sent out from those available at the time.

- Has now know how to organize immunization activities at the OR sites: CHILD field staff find that the HA often arrives for the session in a timely fashion. If CHILD field staff arrive after the HA, they find that the HA has already arranged supplies and set up the area to begin the session activities.

Discussions in previous sections, especially *Assessment of Counterpart Relationships,* and in the upcoming *Findings and Recommendations* section detail activities and systems in which sustainability is expected and mechanisms for achieving and documenting that. A major role that CHILD can play in achieving sustainability during the systems improvement activities is finding ways to keep worker motivation high. This includes identifying incentives to encourage all levels of workers in their jobs: giving credit to field workers for outstanding job performance, initiating mechanisms for field workers to have increased participation with their supervisors for decision-making about their work, implementing a system to give credit to thana managers for accomplishments, and finding a way to have the district recognized at national and or divisional level for its efforts in various activities.

9. Findings and Recommendations

a. Overall

- **CARE is the one of the very few NGOs working with the MOHFW in an implementational project through *apartnering* relationship to improve the existing health systems. The hallmark of partnership in the project represents the opportunity to build sustainability activities into project and observe progress as it occurs. The current time frame for the project is ambitious as it took almost 1 year (in the pilot year) to ensure introductory activities as basis for partnering together. The large number of expected activities puts difficult burden on field workers and CARE staff. However, the CARE staff are very knowledgeable about their work areas and can synthesize project needs.**

- **Regularizing services at the outreach level is the major project accomplishment in everyone's eyes - CARE staff and GOB personnel, CHILD is a catalyst for getting national strategies to the field and implemented.**

- **It is too early for firm conclusions, but there is evidence of improvements in health care delivery systems. The evaluation found anecdotal evidence for :**

  workers doing a better job and spending more time working.

  women moving out of *baris* (house compounds) more easily to come to services, women asking more questions of workers, women being more "open".

  CARE female staff as role models for women (working, riding motorcycles).

  workers just being visible in the community regularly may be contributing to women moving out of *baris*.

i. Short-term recommendations

CONTINUE PROJECT **ACTIVITIES** BUT REFOCUS AND STREAMLINE SOME AREAS

Negotiate phase-out activities individually bythana. Consider negotiating a withdrawal from one thana completely for 2-3 months to see the effect. (See section 9.b for specifics.)

- **Reconsider the social mobilization component carefully and refocus on specific activities to strengthen field workers' abilities to be sensitive to and meet women's perceived needs. (Change/improve work-style skills to continue to get women moving out to use services.) (See section 9.c for details.)**

Implement cross-visits between CHILD and non-CHILD thanas to orient thana managers and field workers.

DOCUMENT AND DISSEMINATE WHAT **CARE** AND THE **MOHFW** ARE DOING IN SYSTEMS IMPROVEMENT/MANAGEMENT STRENGTHENING

Revisit activities such as the MCH-FP Extension Project and the Local Initiatives Project to compare and contrast approaches and determine cross-fertilization of ideas and experiences.

Work with thana managers to synthesize and document the organizational change process in various thanas and in the District.

Substantiate in writing activities such as strengthening EPI service delivery and workable systems for semi-annual Vitamin A distribution rounds.

ii. Long-term recommendations

EXTEND THE **CHILD** PROJECT FOR AN **ADDITIONAL** 4 YEARS

In the next phase, continue the project in the original 5 thanas for the first year through a plan for phasing out systems improvement activities while providing continued technical support for interventions.

Expand into the other 6 thanas, but with a different methodology. Use CHILD thana managers and field workers to introduce project activities to new areas, use a "procedure book" as basis of activities, focus approach thana by thana, do a preliminary assessment of thana management, etc.

b. Systems Improvement

- The methodology being used by CHILD to sustain activities after CARE leaves appears to be effective. There are signs that systems are improving and changes are occurring.

  Managers and workers are willing to spend more time at activities as they see the results of their efforts.

  HA-FWA joint attendance at EPI sites is better in CHILD than non-CHILD areas.

  District-level coordination between the Health and FP wings of the MOHFW is quite strong.

  EPI services are regularized and over 50% of outreach and satellite clinic sites are already merged, providing a wider range of services in community locations for women and children.

  Linkages with government'counterparts are strong and activities can be undertaken jointly.

  Over 70% of planned sessions for outreach and satellite clinic sites were actually held.

- Project activities were necessarily phased in as interventions focused on responded to GOB's perceived needs (EPI first, Vitamin A next).

- Very vertical GOB programs make it difficult to achieve true integration, despite district-level decentralization.

i. Short-term recommendations

NEGOTIATE A PHASE-OUT OF ACTIVITIES FOR CHILD ASSISTANCE BY THANA

CARE should respond to each thana's individual needs/pace for phasing out and facilitate their decision-making on what they are ready to assume[24].

Since thana and district managers are now more comfortable with CHILD assistance, CARE should plan more joint debriefings and planning meetings so that MOHFW participation begins as early as possible in the planning process.'

CHILD should play a key role in clarifying access to various MOHFW Directorate training resources (primarily EPI at this point). This district-specific planning information should be included along with budgeting costs in the yearly planning workshops for EPI and other interventions as may be appropriate.

CHILD should begin informally to identify potential team members for systems-improvement documentation and formalization efforts.

CHILD should explore provision of decision-making training/workshops for MOHFW managers.

REFOCUS SYSTEMS IMPROVEMENT ASSISTANCE TO CERTAIN INTERVENTIONS

CDD (See section 9.g.)

Reinforce the connection between TT and safe delivery so that pregnant women receive this information during antenatal visits. (See next recommendation below.)

USE THE MERGED SITE AS THE FOCUS OF INTERVENTIONS

Strengthen/support merged sites for ensuring services and increasing the range of services available at the community level.

[24] For example, CHILD staff in Biswanath thana feel managers there are not as ready in other thanas to take on CHILD-assisted activities yet because the staff vacancies in their thana were filled comparatively quite late in the project period.

Develop mechanisms for increased linkages between satellite clinic and outreach site at merged sites. Begin with cross-referral for TT/safe delivery information by implementation of a mechanism for HA to refer women coming for TT immunization to be referred to the FWV for an antenatal consult[25].

Document and develop *merged-site management:* what mechanisms need to be developed to ensure the maximum collaboration among workers to meet the needs of women and children.

Explore possibilities to provide team-building exposure to MOHFW field workers.

ii. Long-term recommendations

DISEASE SURVEILLANCE: Explore options for assisting the MOHFW with efforts to improve disease surveillance to track the effect of EPI coverage and CDD efforts.

RESEARCH QUESTIONS TO EXPLORE about service delivery mechanisms: Is attendance at merged sites better than at separate sites? Do we need to assess this? How can we look at this activity and determine usage and access to services? Can we assess at all?

C. Social Mobilization

- Field workers are doing more community visits and holding more group meetings. This field worker visibility is increasing the demand for services. Just having field workers in community tb visit/ask questions may be helping women to move out for services.

- Reaching community groups: Attempts to work with and use the organizational structure of BRDB/community women's groups didn't work out well. The school program is reaching minimal numbers of schools. In addition, responsibility for this work is not within the responsibilities of the MOHFW. It is impossible to assess whether the information is getting into the community and its effect, if it is.

[25] Consider and explore the feasibility of cross-card (mother's card) use and supplying the FWV with a stamp to mark the card to show that she has seen the pregnant woman.

- **CARE staff feel constrained by the need to use GOB messages/materials which are not always deemed appropriate for the field situation.**

- **CARE's mandate is intensive social mobilization to create service demand but this isn't expected to be sustained in the same fashion.**

- **Biswanath thana is experimenting with ensuring that the HA visiting a community for preregistration with the FE is seen at the OR the next day by the FT to determine the short-term effect of the preregistration on mobilizing mothers.**

i. Short-term recommendations

CHILD SHOULD REASSESS THE CURRENT SOCIAL MOBILIZATION STRATEGY INCLUDING THE SCHOOL PROGRAM AND WAYS OF REACHING THE COMMUNITY

- DELETE THE SCHOOL PROGRAM: **Since the school program is not being effective, it is better to free up the field workers' time for more community visits.**

  TRY NEW APPROACHES TO STRENGTHEN THE LINKAGES BETWEEN THE GOVERNMENT AND THE COMMUNITY: **Continue experimenting with approaches such as the Child-to-Child Program. Find "empowed" BRDB or other community women and seek their assistance to work in the community. Eliminate the idea of working with the Imams, village doctors, and other groups'.**

FOCUS ON ACTIVITIES TO STRENGTHEN THE ONE-TO-ONE INTERACTION AT THE HOUSEHOLD LEVEL

Talk to field workers to find out what they like about their jobs. Ask them to define what they could do to get more information from people. Where do these incentives to improve work come from and can CHILD build on these to improve work styles?

Emphasize the "visiting people" aspect of their work rather than targets to fulfil.

Emphasize Interpersonal Communications IPC) such as greeting people, being nicer to them, relating to them more as people rather than "clients".

CHILD staff should find a mechanism to assist the district in IPC refresher training presently on-going (buy credibility to work with field workers on these skills).

Emphasize specific IPC-related activities for field workers during community visits.

ii. Long-term recommendations

NEED TO REASSESS THE SOCIAL MOBILIZATION TOPICS SCHEDULE/CONTENT : **Make the government more aware of other materials more appropriate to the needs in Sylhet. Consider using materials from other NGOs if they have been tested and are useful for reaching certain groups (pilot-testing new materials for the GOB, recognizing need for materials specific to Sylhet situations).**

RESEARCH QUESTIONS TO EXPLORE : **What makes mothers use services (barriers and incentives)? Field worker visits, group meetings or regularity and quality of services? What are the CARE staff training needs for improving social mobilization skills. How far is CARE doing GOB field workers' work for them?**

d. Monitoring and Evaluation

- **Combination of monitoring system with yearly surveys is helping document progress internally (within CARE) and externally. However, some information is being collected purely to meet external reporting requirements and is not appropriate for this type of project (e.g., numbers of mothers educated on child survival topics).**

- **Development and joint testing of some forms have been accepted by the MOHFW :**

  Cold-chain Monitoring Checklist **has been adopted by CS for district.**

  Satellite Clinic Reporting form **approved by DD-FP as adjunct to MOHFW *FP and MCH Reporting Form***

- **Information is being used at all levels for program review. It is especially helpful for EPI performance discussions with district and thana managers.**

  Managers aren't afraid to criticize their thana's performance as they have found the ability to solve their own problems and improve performance - e.g. no blame for coverage "decreases" as data quality improved.

  A joint M&E workshop with counterparts was very productive for identifying usefulness of certain indicators/data, and managers outlined areas where the MOHFW wants information.

- **CARE is collecting information whose use/purpose isn't defined clearly, despite the M&E workshop.**

  The HIS has too many forms and people are tracking too many *perceived* outputs. (HIS forms 1 and 2 had biases, Form 3 still has biases.)

  HIS Forms 1 and 2 Feasibility study is a lot of effort to do quarterly. The evaluators feel that this does not justify the results obtained from it.

  Technical Officer (in charge of data management) is posted in Dhaka so field analyses are done in Dhaka and feedback to the field is not timely.

- **AID requirements for the KAP survey target group (mothers of under-twos) is not adequate for this type of project and ignores the cultural issues specific to Sylhet (primarily, large numbers of women whose husbands are away for extended periods of time).**

- **Information needed from qualitative data collection methods may already be available, even if not specific to Sylhet. It is highly likely that research on mother and community knowledge, beliefs, and behaviors related to breastfeeding practices, diarrhea, childhood nutrition, and other topics of interest in CHILD are readily available for Bangladesh.**

i. **Short-term recommendations**

THE PROCESS FOR DATA ANALYSIS AND PROVIDING FEEDBACK TO THE FIELD MUST BE AS DECENTRALIZED AS POSSIBLE FOR THE MAXIMUM USEFULNESS TO STAFF: **Relocate the Technical Officer to Sylhet where the data is so that he is on-site to assist the staff to improve their understanding of what data they are collecting and how it can be used.**

SUSPEND PLANNED DATA COLLECTION ACTIVITIES UNTIL EXISTING RESOURCES CAN BE REVIEWED: **Investigate the availability of qualitative research and other projects' experiences on various topics for Bangladesh and use these as background information for targeting activities. However, qualitative research will likely be required to determine :**

- **barriers to increased participation of community mothers.**
- **effectiveness of strategies such as** CHILD-TO-CHILD.
- **strategies to increase interpersonal communication between the field worker and the community.**

CAREFULLY CONSIDER THE FEASIBILITY TEST OF THE QUARTERLY **HIS FORMS 1** AND **2DATA** COLLECTION ACTIVITY : **How does this quarterly effort help the program except for finding the data registration inconsistencies in those actually sampled and perhaps allowing managers to find blame with workers in the sample? Can CARE and the thana managers get this information in another way (e.g. finding those not registered) that will contribute positively to better registration? For example, CHILD could test the feasibility of using a village volunteer for routine registration of vital statistics to examine the effect on HA/FWA work *vis-a-vis* their registration books.**

CLARIFY THE USE OF **HIS** FORM **3**

Using a version of this form in a semesterly random sample of observations of site performance is more appropriate and will validate routinely collected GOB information such as FWA/HA joint attendance at sites.

This is a useful checklist for supervisors for monthly documentation by FTs of the status at 5 OR sites every month for discussion of site-based problems, but do not report those percentages.

METHODOLOGICAL SUGGESTIONS FOR THE FINAL EVALUATION AND SURVEY

The final evaluation should be participatory. Add District/thana managers to the process.

Survey/target population: Add the other 6 thanas so comparisons can be made and baseline can be established (i.e., services available/used in other thanas because field worker vacancies were filled vs. from systems improvement).

Survey/sample: The sample should be much larger than that based on 20% diarrhea prevalence; cell sizes for TT and others diseases are very small[26].

Survey/sample size: Consider the feasibility of using a larger study population of all women (specific sub-sample for under-2s) to determine:

whose husband is away and for how long (Is there really 8-9% "natural" contraception in Sylhet?).

TT status by last pregnancy (not just mothers of under-2s).

differential effects of project improvements over past 3 years; are younger children being vaccinated in a more timely fashion?

numbers of children: do women with several children vaccinate the later ones?

Survey: Add under-l Vitamin A distribution by card review as well as history.

e. EPI

- There is evidence of increasing use of immunization services (increased full and partial coverage). In the evaluators' *bari-walkthrough* observations/field interviews:

  Many mothers produced their child's card; it was clean, in its plastic cover, not torn.

  Few mothers said they had TT vaccination or could produce TT cards.

  Field workers feel that mothers seem to be bringing children in earlier for vaccination, and that, once children start to be vaccinated, they will finish vaccinations.

  Children who start the immunization process late (i.e., close to the age for measles immunization) may not be finishing.

[26] If sampling a population to determine responses to a mix of indicators, sample size calculations should take into account all of those indicators and take the largest sample numbers. For example, given the low "prevalence" of women vaccinated for TT2+ who had cards, this "prevalence" could be used for sample size calculations.

Some mothers knew when to go back for vaccination sessions.

- Barriers to children and mothers being fully immunized are due in part to field workers and supervisors. There have been changes in GOB policies along with difficulties communicating these changes to the field:

  The TT vaccination schedule is not understood; workers cite changes in schedule and target group over the past 3 years. In addition, field workers have missed opportunities to vaccinate mothers with TT when they bring their children to the outreach site.

  There have also been mixed messages on the target age group for vaccinating children (emphasize under-ones, but vaccinate all under two): Workers do not have a way to identify 12-23 months target group. There is also no mechanism now to document these vaccinations as the new tally books do not include the 12-23 mos. category. Field workers' misunderstandings include :

  If no vaccination is begun by 1 year, then don't vaccinate that child.

  Do they encourage children to continue if children are close to 1 y.o. and have already gotten measles?

  They don't understand the relationship between disease and vaccination. ("Measles doesn't occur under 9 months so don't report it." Do they also believe that children over the age of 1 don't get measles?)

- The strategy of having extra sessions after the rainy season for catch-up of those who missed being vaccinated: There is no apparent evidence of difference between 1991 and 1993 (for DPT3 and measles) except in Bishwanath thana.

i. Short-term recommendations

FIELD WORKERS NEED ONGOING REFRESHER TRAINING ON SPECIFIC BARRIERS TO VACCINATION DELIVERY

Refresher training should center on TT (clarifying/applying TT-5-dose strategy and target group) and the relationship of EPI and the 6 diseases to children as they get older.

Training should be oriented to problem-solving activities to apply vaccination concepts/policies to real situations.

Clarify at national level and implement :

an acceptable method for identifying, delivering and documenting TT to non-pregnant women. If none, discuss and develop at district/thana level.

reaching 12-23 mos. target group for vaccinations and how to document/target them.

CHILD SENIOR STAFF SHOULD EXAMINE THE INTERMEDIATE USE OF SERVICES IN THE PRESENT SURVEY DATA

Use MT survey information on dates of immunization (if cell sizes not too small) to look at trends in :

average age of starting immunization to verify field workers belief that mothers bring children in at 3-6 months to start.

likelihood of finishing vaccination if child starts late (i.e., "measles is the last shot").

dropout rate from DPT3 to measles.

stratify on age by immunization status including partially-immunized (i.e., 23 mos. less likely to be vaccinated because services were not as organized or available 2 years ago as 1 year ago)

sex differences (if available)

immunization status of under-ones to examine changes in use of services (coming earlier, coming more regularly for vaccination), card retention, etc. (service indicators).

Use this information to focus for service coverage efforts and to target social mobilization efforts.

Coordinate with EPI Directorate and CCC/JSI Urban EPI to discuss feasibility of using EPI SCORE[27] in Sylhet for EPI performance review to focus attention away from only coverage statistics.

EXPLORE MECHANISMS TO ENSURE APPROPRIATE IMMUNIZATION

VACCINATIONS SHOULD BE AVAILABLE IN A TIMELY FASHION: **Explore feasibility of making extra sessions before the rainy season so that children who might start very late after the rainy season won't become dropouts.**

STRENGTHEN TARGETED ELIMINATION OF NNT THROUGH CROSS-REFERRAL MECHANISM BETWEEN SATELLITE CLINIC AND OUTREACH SESSION AT MERGED SITES: **Emphasize linkage to FWV for safe delivery information/motivation using the merged site as focus of efforts. (See above for additional recommendation on this subject.)**

ii. Long-term recommendations

INCLUDE ASSISTANCE WITH DISEASE SURVEILLANCE FOR REPORTING ON MEASLES AND DIARRHEA: **CHILD can be helpful managerially in implementation of efforts to improve surveillance as the final link to prove the impact of high vaccination coverage.**

f. Family Planning

- **FP use seems to be increasing, but the K&P survey sample doesn't identify long-term users (i.e., pregnancy more than 2 years previously) or look at how many children the woman has already. Are women whose husbands are away still being visited for FP motivation? Are their children being served? Are they** getting TT?

- **FWA/FWV motivational discussions are often delivered by rote.**

- **MOHFW FP Wing meetings such as the MCH Committee Meeting, Union FP Coordination Committee Meeting, and the FP Performance review meeting to discuss and resolve issues relating to FP service delivery have not been as successful in implementation and utility as those in the Health Wing.**

[27] includes TT2+ coverage of pregnant women, measles coverage, BCG-measles dropout rate, % of sessions held-vs-planned. % sessions with FWA attendance at site.

- **The *Satellite Clinic Reporting Form* has been accepted by the DD-FP as a useful adjunct to the *FP and MCH Reporting Form.***

i. Short-term recommendations

IMPROVE THE QUALITY OF FP ACTIVITIES AND SERVICES

Use the merged site to improve relationships with the FWV and determine how she motivates and who she motivates at site.

Re-examine how FWAs visit target couples: finding women whose husbands are away.

Assess FWA interpersonal communication skills and target CARE field staff support to meet the needs identified.

Encourage local-level collaboration between HA and FWA and strengthen collaboration of all workers at the merged site.

Strengthen HA referrals for FP motivation at the merged site.

Continue to work with CARE's NGO-SP[28] to maximize efforts.

REVIEW THE SUCCESS OF FP MANAGEMENT STRENGTHENING AND INSTITUTIONAL DEVELOPMENT

Consider dropping the FP-based meetings after discussions with thana and District officials about the lack of interest in the meetings and the inability to resolve barriers to increasing FP services and access.

Support continued discussions with workers and managers on the experience with the *Satellite Clinic Reporting Form* to better define its usefulness and increase its acceptability and communicate this to national level.

ii. Long-term recommendations

QUESTION: SHOULD CARE ENVISION FP AS PART OF AN INTEGRATED MATERNAL CARE COMPONENT?

[28] NGO Services project strengthens FP service delivery in existing CARE projects and local NGOs.

g. CDD

- **It is beyond the project's scope to work with CDD as a preventive strategy (latrines, improved personal and domestic hygiene). Prevention of morbidity/mortality from dehydration of diarrhea is a possible emphasis. CHILD had planned to work with village doctors for CDD training but has been delayed in this plan because GOB materials haven't been finalized. *ORT Corners* have been established in at least 1 project thana and a District-level CDD coordinator is soon to be hired.**

- **Women seem to have purchasing power to buy ORS packets which seem to be readily available. Mothers' knowledge of ORS is high, but what is the acceptability? Is this a perceived need of mothers (treating for dehydration)? Evidence from surveys shows that mothers are giving same/more breastmilk during diarrhea even if food and other fluid consumption isn't adequate.**

i. Short-term recommendations

EMPHASUE DIARRHEA TREATMENT AS DIARRHEA SEASON IS BEGINNING

Test the feasibility of developing and implementing a strategy to target education at the OR site prior to starting vaccination session, focusing on:

the acceptability of ORS (e.g. prepare it and give it to the child/mother to drink)

amount to give to children during diarrhea episode, in understandable ways.

participatory active learning module (PAL) on why rehydration is important.

ASSESS THE STATUS OF DISTRICT-LEVEL **CDD** ACTIVITIES AND **CHILD's** ROLE

CARE should inspect ORT Corners elsewhere to determine how they function and what the implementational experience has been. From these visits, CHILD should define the limits of assistance CHILD can provide.

It is not feasible for CHILD to work with village doctors on CDD training within this project.

ii. Long-term recommendations

CARE SHOULD STRIVE TO INTEGRATE A TRUE **CDD** APPROACH INCLUDING PREVENTIVE AND TERTIARY CARE **ACTIVITIES.**

h. Vitamin A

- Field workers believe more mothers know about Vitamin A and are asking for their child to have it ("medicine for the eyes"). Field workers and mothers believe there is less nightblindness in communities.
- Field workers are distributing the Vitamin A capsule to the child rather than handing it over a large amount of VAC to an adult to distribute.
- Joint participation by the HA/FWA in semi-annual distribution rounds is working out well in Sylhet District.

i. Short-term recommendations

INSTITUTIONALIZE VITAMIN A DISTRIBUTION ACTIVITIES

Document planning/implementing exercises for Vitamin A distribution including joint HA/FWA participation.

Increase coordination with HKI for technical support on Vitamin A.

i. CARE-Specific

- CARE has gained much credibility with clear-cut interventions (EPI, Vitamin A). Focusing on other interventions may be more difficult as interventions (and targets/achievements) are less defined. CHILD staff are very task-oriented despite much of their work being facilitation and active coaching (in part, donor- and organization-driven to meet reporting requirements). The project is still very focused on collecting data without always a clear understanding of what, why, and how to use.
- The project has run on extremely tight budget since the start, because of unexpected funding cutbacks. This has:

  caused extensive senior staff time and attention to budget reworking

  impeded project's ability to access technical support for planned qualitative research activities, review of the HIS/M&E systems, documentation and dissemination endeavors, and representation at international meetings and conferences.

- **CHILD's very full set of project activities has hampered project staff's ability to be innovative. (Staff cannot look at quality of services because they must spend so much time working to achieve targets.)**

i. Short-term recommendations

ADDRESS STAFF DEVELOPMENT NEEDS

Refocus staff efforts on products they can produce for CHILD and put a value on those activities.

Focus staff on what they do to accomplish activities as linked to the outcome of the activity.

Educate staff about why workers work so they can use that information when they are working with GOB field workers.

IN FUTURE PROGRAM/PROJECT ACTIVITIES, CONCENTRATE ON MANAGERIAL EFFORTS AND DON'T GET CAUGHT UP IN AREAS BEYOND WHICH STAFF HAS TECHNICAL CAPABILITY OR "CREDENTIALS" (E.G. CLINICAL FP SERVICES).

ii. Long-term recommendations

CARE SHOULD RECONSIDER HAVING 2 DIFFERENT DESIGNATIONS FOR FIELD STAFF; THE PRESENT SYSTEM PARALLELS THE TWO WINGS OF THE MOHFW SYSTEM.

Appendix

Appendix A: Project Indicators, Targets, and Achievements

	INDICATOR		Baseline Survey 10/91 (per cent)	Mid-term Survey 1194 (per cent)	6/94 Target	Final 8/95
EPI	Increase to 50% (card) the number of children 12-23 months fully immunized.		6.1	34.6 (n=44)	45%	50%
	Reduce the dropout rate to 10%.	OPV1-3	45.8	20.0 (n=56)	*none stated*	10%
		DPT1-3	52.4	20.0 (n=56)		
		DPT1-M	52.0	14.0 (n=56)		
	Increase the retention of maternal TT card to 50%.		12.2	16.2	*stated*	50%
	Increase. to 50% (card) the number of women aged 15-45 years who were protected during their last pregnancy	TT1	2.6	3.0		
		TT2/TT2+	10.0	14.0	30%	50%
FP	Increase to 20% the proportion of mothers using a contraceptive method among mothers who desire no more children in the two next *years.*		10.0	22.5 (n=260)	23 %	20%
CDD	Increase to 65% the percent of children less than 24 months with diarrhu in the past two weeks. who were treated with ORT.	Total	39.3	35.8 (n=74)	55%	65%
	Increase to 50% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more breast-milk.	Total (more and same)	56.2	69.8 (n=53)	*none stated*	50%
	Increase to 50% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more fluids.	Total (more and same)	37.1	34.0 (n=53)	*none stated*	50%
	Increase to 30% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more food.	Total (more and same)	13.4	11.3 (n=53)	*none stated*	30%
VIT A	Increase to 50% the number of children aged O-72 months who receive Vitamin A supplements during the last six months.	Total	15.8	51.0 (n=154)	*none stated*	50%
		0-11	N/A	40.6 (n=71)		
		12-23	N/A	65.4 (n=83)		
Total		Total	311	302		
		0-11 mor.	63.3 (n=197)	57.9 (n=175)		
		12-23 mos.	36.7 (n=114)	42.1 (n=127)		

Appendix B: Team Members/Key Contacts

Team Leader: Susan J. Griffey Brechin, DrPH, BSN

Team Members

Dr. Sayeed Hashemi, Social Scientist, Development Research Center

Sumana Brahman, Health & Population Sector Coordinator, CARE-Bangladesh

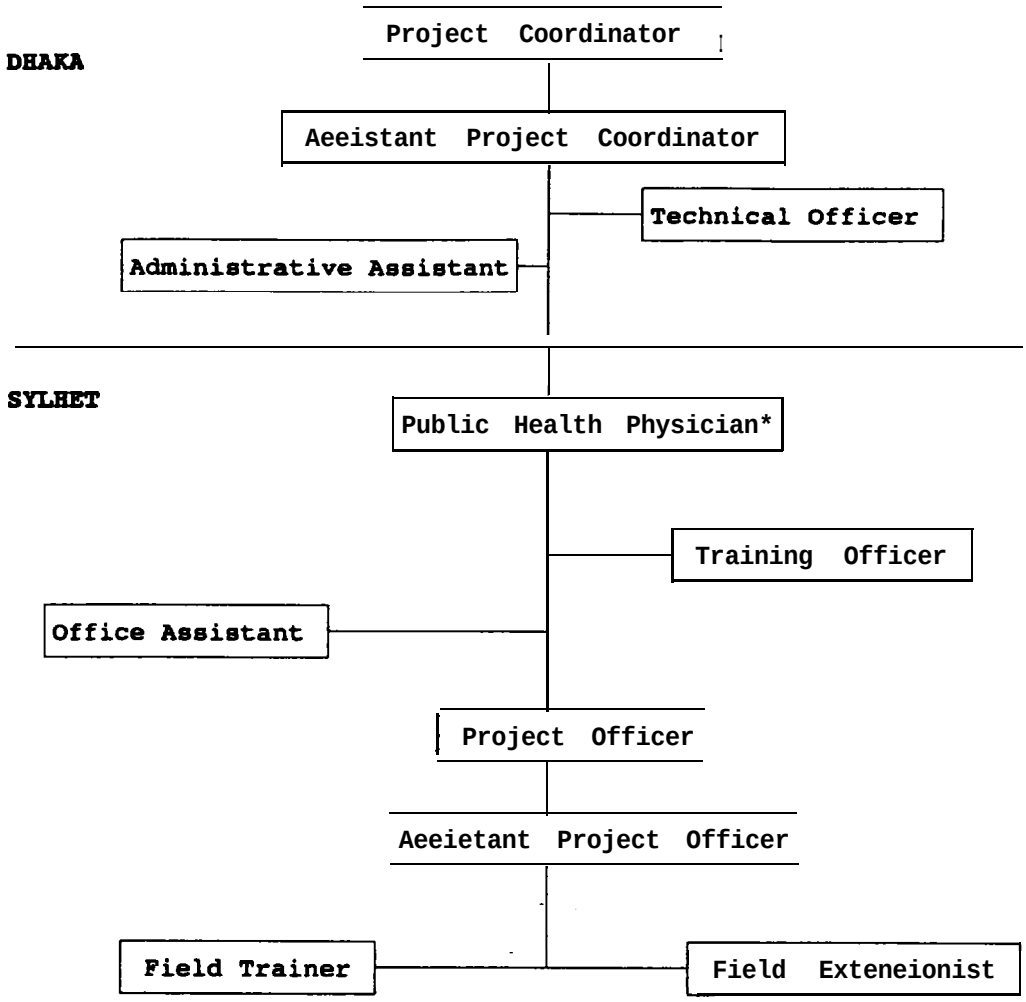
Dr. Florence Durandin, Project Coordinator, CHILD Project, CARE-Bangladesh

Dr. A.T. Nizam U. Ahmed, Asst. Project Coordinator, CHILD Project, CARE-Bangladesh

Counterparts/key contacts:

1. **Dr. M. A. Mazid, Project Director-EPI, EPI HO, Dhaka.**
2. **Dr. Ashraf Hossain, Project Director-CDD, NCDDP Office, Dhaka.**
3. **Dr. G.M. Mahamood, Civil Surgeon, Sylhet District, Sylhet.**
4. **Mr. Saidur Rahman, DD-Family Planning, Sylhet District, Sylhet.**
5. **Mr. Mahaboob Sharif, Program Officer, Health & Nutrition section, UNICEF, Dhaka.**
6. **David Piet, Deputy Director, Office of Population & Health, USAID, Dhaka.**
7. **Mr. Nick Ritchie, Deputy Director, CARE-Bangladesh, Dhaka.**
8. **Mr. Edward Brand, Country Director, CARE-Bangladesh, Dhaka.**
9. **Dr. Mary Carnell, Chief of Party, CCC/JSI Urban EPI Project, Dhaka.**

Appendix C: Organizational chart: CHILD Project



- Also the Project Manager

Appendix D: List of Key Documents

LIST OF KEY DOCUMENTS

1. Project Monitoring tools, includes supervision/monitoring checklists, reporting formats & Annual Implementation Plan (AIP 1.2).
2. Guideline for project monitoring/supervision tools and reporting formats of FY-94.
3. Baseline survey report, October 1991.
4. K & P survey report, November 1992.
5. Mid Term Evaluation (MTE) survey report, January 1994.
6. Project Implementation Report (PIR): 2 reports (semesterly) of FY-92.
7. Project Implementation Report (PIR): 2 reports (semesterly) of FY-93.
8. Project implementation Report (PIR) of FY-94.
9. Monitoring & Evaluation workshop report, November 1993.
10. 1st Annual report to USAID, 1'992.
11. 2nd Annual report to USAID, 1993.
12. Quarterly reports to USAID of 1992, 1993 & 1994.
13. Detailed implementation Plan (DIP) of CSVII & CSVIII.
14. Project Proposal (MY P).
15. Annual Implementation Plan (AIP) workshop report.
16. Health Information System (HIS) with Guideline.
17. NGO-SP Baseline Community Needs Assessment

Appendix E: List of Educational Materials for Social Mobilization

NAME OF TRAINING MATERIALS	PURPOSE	USED BY	PUBLISHED BY
EPI 1. EPI Registration book 2. Tally Sheet 3. EPI cards (child and mother) 4 . EPI Flipchart 5. Six Diseases poster of EPI 6. T.T. Poster 7. Injection poster 8. Religious poster in EPI 9. Site poster in EPI 10. HA/FWA training manual on EPI 11. EPI Technician manual	Training of HAIFWA and health education at the community	HAIFWA and CHILD staff	EPI HQ
VITAMIN A 1. Flipchart on Vitamin A 2. Vitamin A poster 3. Nutritional blindness poster 4. Vitamin A booklet and flashcards	Training of HA/FWA and health education at the community	HAIFWA and CHILD staff	Health and FP directorate
FAMILY PLANNING 1. Flipchart on FP a. FWA Flipchart b. Why FP is Needed flipchart c. FP Methods flipchart 2. FP poster (2 children) 3. FP oral pill poster 4. Poster on FP methods 5. FWC manual 6. Other FP posters and booklets	Training of HAIFWA and health education at the community	HAIFWA and CHILD staff	FP directorate
DIARRHOEA 1. Flipchart on diarrhoea 2. ORS poster 3. Treatment of diarrhoea poster 4. Safe water supply poster	Training of HAIFWA and health education at the community	HA/FWA and CHILD staff	MCH Directorate and Health Education Bureau
NUTRITION 1. Flipchart on Nutrition 2. Nutritional Blindness poster 3. Health of children and nutrition 4. Child Are poster 5. Other related posters and booklets	Training of HAIFWA and health education at the community	HA/FWA and CHILD staff	MCH Directorate and Health Education Bureau

Appendix F: Summary of Mid-Term Survey

CHILD PROJECT MID-TERM K&P SURVEY SUMMARY (January 1994)
Prepared by Florence Durandin, MD, Project Coordinator

BACKGROUND INFORMATION

CARE-BANGLADESH implements the Child Health Initiatives for Lasting Development Project (CHILD) in Sylhet District of the Chittagong Division. Since October 1991, USAID has funded CHILD, which operates in 5 thanas (sub-districts). The target population of the project area is 431,854, and includes all children under age 6, and all women of reproductive age (15-49 years). CHILD is a Child Survival program which comprises four major interventions: Expanded Program for Immunization (EPI), prevention of Vitamin A deficiency, promotion of appropriate home case management of diarrhea1 episode, and Family Planning.

The project's main strategy is to work with the Ministry of Health and Family Welfare (MOHFW) counterparts, and to strengthen the MOHFW's capability to deliver basic child and maternal care services at community level. This approach is combined with a social mobilization component, aimed to increase the mothers' knowledge on basic health messages, to make them aware of the available outreach services, and increase their demand for and use of these services.

In January 1994, CARE-BANGLADESH conducted a Mid-Term Evaluation survey in the CHILD project area, in the Sylhet district. The purpose of the survey was to assess progress achieved thus far after two years of project implementation.

Survey methodology

The survey used the same standardized Knowledge and Practice (K&P) questionnaire as was used for the baseline and annual surveys. In agreement with the Director of the Johns Hopkins University Child Survival Support Program, we selected 19 questions to measure the major Child Survival coverage indicators related to the project interventions. Questions focused on vitamin-A capsule coverage, diarrhea home management, immunization coverage and use of family planning methods.

The sample included 302 mothers 15 to 49 years old with children under age two. The standardized WHO 30-cluster sampling method was used and the population figures of the project area adjusted for 1993. The ward was taken as the smallest unit to calculate the cumulative population and randomly select the clusters. One village for each selected ward was then randomly selected. The method for visiting households in each cluster followed the usual steps for random selection.

To avoid potential bias during data collection, CHILD hired external surveyors. The survey team included 12 surveyors and 10 supervisors. The survey was conducted

from January 22 to 29, 1994, including three days of in-house survey team training, three days of data collection, one day for manual tabulation, data entry in the EPI-INFO software, and presentation of preliminary results.
Further data processing and analysis and finalization of the report were completed later. Analyses with EPI-INFO included frequency distributions of all variables, cross-tabulation with specific variables (age of the child), and comparison with previous survey results (including statistical tests).

MAIN FINDINGS OF THE MID-TERM SURVEY

The main findings of the Mid-Term Evaluation survey suggest that:

- The EPI operations have significantly improved in the project area since the inception of the CHILD project :

  The percent of 12-23 month-old children fully immunized increased from 6% to 35% (card only).

  The retention of child immunization card doubled, from 21.2% to 42.7%

  The drop-out rate for DPT1 -Measles decreased from 52% to 14%

- The Vitamin A Capsule (VAC) coverage among children less than two years old, as reported by their mothers, has increased from 15.8% to 51% .

- The home management of diarrhea by mothers has not significantly changed. The Oral Rehydration Therapy (ORT) use rate is 40%, and it seems that breastfeeding patterns during a diarrhea1 episode have improved. However, mothers often combined continuation of breastfeeding and use of ORT with less appropriate actions, such as a wide use of medicines to treat diarrhea.

- The use of contraceptive methods among the mothers who do not immediately want another child has increased from 10% to 21.2%

RECOMMENDATIONS AND CONCLUSIONS

This K&P survey, conducted at the mid-term of the project life, showed clear progress of the coverage indicators of the immunization and vitamin A capsule distribution programs. These results obtained after two years of project implementation are encouraging and illustrate that the strategy used by the CHILD project to strengthen the MOHFW outreach service delivery system is effective. However, more time and different approaches might be required to address issues related to behavioral change, such as those needed for the control of diarrhea1 diseases. It seems that ensuring availability of ORS packets at the outreach site and explaining how to prepare home-made saline solution is not sufficient to ensure that mothers will practice appropriate

management of a diarrhea1 episode. The project will explore other strategies such as providing relevant counselling to the mothers at the ORT Corner.

This survey is part of the mid-term evaluation process of the project. In addition to the analysis of the trend of the Child Survival main indicators, the mid-term evaluation will assess other aspects of the project such as the social mobilization activities, the training methodologies, the partnership with the MOHFW counterparts, and the sustainability of the community-based activities.

Appendix G: Mid-Term Evaluation Tools

(NOTE: Spacing collapsed to save space)

IDNUM :_____ CLUSTER #____

MID-TERM EVALUATION SURVEY, 1994

CHILD PROJECT

At the onset, please give your identity to the mother and start the interview with her consent. All questions are to be addressed to the mother (women 15-49 years old) with a child under two (less than 24 months old)

[Interview date __/___/94 (dd /mm) Reschedule interview ___/___ /94] (dd /mm)

Interviewer name _____

Supervieor name_____

Thana _____ Union _____

Ward #_____ Village name: _____

1. Name and age of the mother Name _____ Age (years)_____
2. Name and age of the child under two years old
   Name _____ Sex: M [ ] F [1
   Birth date _ / _ / _ (dd mm yr)

Vitamin A coverage

3. Has (name of child) been given a capsule of vitamin A since the last six monthe ?
   Yes [ ] No [I

Diarrhoeal Diseases

4. Has (name of child) had diarrhoea during the laet two weeks ?
   Yee [ ] No . . [ ] --> Go directly to question 09. You need not to ask the queetione 05 to 08.

5. During (name of child)'s diarrhoea did you breast-feed ? (Read the choices to the mother & [x) cross the appropriate answer box according to the mother's response.)

   1. more than usual [ ] 2. less than usual [ ]
   3. same as usual [ ] 4. etopped completely [ ]
   5. child not breastfed [I

6. During (name of child)'s diarrhoea, did you provide (name of child) with fluids (eg. coconut water, tea, fruit juice, sarbat, plain water, bottle milk) other than breast-milk? (Read the choices to the mother & [x] cross the appropriate answer box according to the mother's response.)

   1. more than usual [ ] 2. same as usual [ ]
   3. less than usual [ ] 4. stopped completely [ ]
   5. child exclusively breastfed [ ]

7. During (name of child) diarrhoea, did you provide *(name* of child) with solid/semi-solid food such as bhat, lei, jau, khichuri, banana.....? (Read the choices to the mother & [x] cross the appropriate answer box according to the mother's response.)

1. more than usual [ ] 2. same as usual [ ]
3. less than usual [ ] 4. stopped completely [ ]
5. child exclusively breastfed [ ]

8. When (name of the child) had diarrhoea, what treatments,if any, did you use? (Multiple answers possible; record all answers given by mother & [x] cross mark appropriate answer box(es))

a) nothing [ ]
b) ORS sachet [ ]
c) sugar-salt solution/LGS [ ]
d) cereal based ORT [ ]
e) infusions or other fluids [ ]
f) anti-diarrhea medicine or antibiotics [ ]
g) other (specify) _____ [1

Immunizations

9. Has (name of child) ever received any immunizations ?
1. yes 2. no 3. Do not know /Do not remember [1

10. Do you have an immunization card for (name of child) ?

1. yes [ ] ---> (must see the card)
2. lost it [ ] ---> Go to question 14
3. never had one [ ] ---> Go to question 14

11. Look at the vaccination card and record the dates of all the immunizations in the space below (dd/mm/yy)

BCG		--/--/--
OPV	1st	--/--/--
	2nd	--/--/--
	3rd	--/--/--
DPT	1st	--/--/--
	2nd	--/--/--
	3rd	--/--/--
Measles		--/--/--

12. Look again at the immunization card, and indicate if there is a space to record vitamin A capsules.

yes [1 no [1 ---> Go to question 14

13. If yes, record the dates of all vitamin A capsules given to this child in the space below.

	(dd/mm/yy)
1st	--/--/---
2nd	--/--/---
3rd	
4th	

MATERNAL CARE

14. Do you have a TT card ?
    1. ye6 [ ]---> (must see the card)
    2. lost it [ ]---> Go to question 16
    3. no [ ]---> Go to question 16

15. Look at the TT card and record the number of TT shots in the space below:
    1. one [1
    2. two *or more* [ ]
    3. none [ ]

16. Are you pregnant now ?

    yes [ ]---> Stop your interview. You need not to ask the questions **17,18,19.** Thank the interviewee.

    no [ ]---> Go to question 17

17. Do you want to have another child in the next two years?

    1. yes [ ]---> Stop your interview. You need not to ask the questions **18,19.** Thank the interviewee.
    2. no [ ]---> Go to **question** 18

18. Are you currently using any method to avoid/postpone getting pregnant?

    1. yes [ ]---> Go to question 19
    2. *no* [ ]---> Stop your interview. You need not to ask the question 19. Thank the interviewee.

19. What is the main method you or your husband are using now to avoid/postpone getting pregnant? {Multiple answers possible; record all answers given by mother & [x] cross mark appropriate answer **box(es)**}

    1. tubal ligation/vasectomy [ ]
    2. **Norplant** [ ]
    3. injection [ ]
    4. pill [ ]
    5. IUD [ ]
    6. barrier method/diaphragm [ ]
    7. condom [ ]
    8. foam/gel [ ]
    9. exclusive breast-feeding [ ]
    10. rhythm [ ]
    11. **abstinence** [ ]
    12. coitus interruptus [ ]
    13. other [ ]

The interviewer should stop her interview and finally thank the interviewee for her cooperation.

COMMUNITY INTERVIEW

1. What do you know about the CARE project?
2. What do you feel is one of the most important things this project has done for your and your community?
3. What has the project changed in your community?
4. What changes have you noticed in the worker's practices in your area since the project started?
5. Before the project started, how did you solve the health problems you identified?
   a. where to go for immunizations
   b. where to get FP supplies
6. How have things changed in terms of your linkages with the GOB workers?
7. How do you think you can become closer to the workers?
8. What should the community do to increase the demand for services?
9. What do **you** think the CARE project **should help** you with?
10. How does the MOHFW help you take care of health **concerns?**
11. Is there anything else you want to tell us or ask us?

Comment on the worker's relationships with the community (known, accepted, etc)

ACTIVITY OBSERVATION

Location _____ Date _____

1. What is being observed
   ___ formal session (Describe) _____
   ___ individual/group discussion (Describe) _____
   ___ informal contact (Describe) _____

2. Who is being observed _____

3. For how long and when is it being observed _____

4. WORKERS: HA FWA FE ___ FT ___ OTHER _____

   a. No. and type of contacts observed: _____

   b. Types of services being given _____

   c. Quality of services being given _____

   d. Types of communications given: _____

   e. Quality of communications:
      i. methods used

_____

      ii. how delivered (discussion vs. rote, explained vs. authoritarian)

_____

      iii. follow-up on previous work or new discussion

_____

5. GENERAL OBSERVATIONS

   a. What positive things did you observe?

_____

   b. What negative things did you observe?

_____

6. Comment on the worker's relationships with the community (known, accepted, etc)

_____

KEY INFORMANT INTERVIEW: HEALTH WORKERS

1. PROJECT KNOWLEDGE: What do you know about the CARE project?

2. KEY CONTRIBUTIONS: What do you feel is one of the most important things this project has done in your **district/thana?**

3. ACHIEVEMENTS:

   a. What has the project changed in your work area?
   b. How has your own work practice changed since the project started?
   c. What do you think about having a CARE partner to work with and how has it helped you or been a problem?

4. OBSTACLES: What obstacles/problems do you have in working with an external NGO:

   a. change in relationship between worker and GOB supervisors
   b. increased complaints from communities

5. IMPROVEMENTS: What would you suggest to add to or change about the project to make it more effective?

6. SUSTAINABILITY:

   a. What do you think will happen after the project finishes its work?
   b. What changes do you expect to see in the delivery of services and in the communities?

7. TRAINING:

   a. Have you received any training in the last 3 years?
   b. Have you received any of this training from CARE?
      i. What type?
      ii. What new things did you learn from this training?
      iii. How did you apply them in your job?
      iv. What did you think about this training?
   c. What additional training do you think you need?

8. COMMUNITY:

   a. When the project started, how did you solve the community problems you identified?
   b. How have things changed in terms of your linkages with the community?
   c. What has been CARE's impact in this relationship?
   d. What do you want the community to do to help you?
   e. How do you think you can become closer to the community?

9. Is there anything else you want to tell us or ask us?

KEY INFORMANT INTERVIEW: DISTRICT AND THANA OFFICERS

1. PROJECT KNOWLEDGE: What do you know about the CARE project?

2. KEY CONTRIBUTIONS: What do you feel is one of the most important things this project has done in your district/thana?

3. STAFFING ACHIEVEMENTS: What changes have you seen in workers in your district/thana since the project started:
   staffing
   6: attendance
   c. morale/work style
   d. effect/impact

4. (DISTRICT OFFICERS) IMPACT:
   a. What differences do you see between project and non-project thanas in terms of:
      i. worker performance
      ii. improved health status of women and children
      iii. community participation
      iv. other
   b. How do you feel that the project has helped improve planning and monitoring of the district's activities?

5. OBSTACLES: What obstacles/problems do you have in working with an external NGO:
   a. increased complaints from workers
   b. increased complaints from communities
   c. problems at Divisional level

6. IMPROVEMENTS: What would you suggest to add to or change about the project to make it more effective?

7. SUSTAINABILITY:
   a. What do you think will happen after the project finishes its work in 1% years?
   b. How will you continue to provide the services you have now and what will be the additional costs?
   c. What changes do you expect to see in the health workers, the delivery of services, in the communities?

8. COMMUNITY:
   a. What do you feel that the GOB and CARE have done to increase community awareness and demand for services?
   b. What should the community do to help the workers do a more effective job?
   c. What do you think has been the impact of CARE on the community-worker relationship?

9. Is there anything else you want to tell us or ask us?

KEY INFORMANT INTERVTEW: CARE STAFF

1. KEY CONTRIBUTIONS: What do you feel is one of the most important things CHILD has done?

2. How long have you been working with the project?

3. TRAINING:
   a. What do you think of the training you have received from CARE7
      i. Has it been relevant?
      ii. What new things did you learn from this training?
      iii. What impact has this had on your work?
   b. What additional training do you think you need?

4. GOB RELATIONSHIPS/WORK:
   a. What changes have you seen in the thana generally since this project started?
   b. What changes have you seen in the GOB workers in your work area?

5. OBSTACLES: What problems are there in the GOB and/or in the CARE project for which there are solutions that could be implemented?
   a. merged sites
   b. EPI
   c. FP
   d. rainyseason

6. MIS: How do you use information such as EPI coverage, numbers of mothers using ORT for diarrhea (from the analyses of the CARE data collection system) in your work?

   (SR. STAFF: How do you use this information for programming? What impact do you it has had on project programming?)

7. COMMUNITY:
   a. How have things changed in terms of community linkages with the GOB workers?
   b. What has been CARE's impact in this relationship?
   c. How do you think the workers can become closer to the community?

8. IMPROVEMENTS: What should CARE do to improve (add to or change about) the project to make it more effective?

9. SUSTAINABILITY:
   a. What do you think will happen after the project finishes its work?
   b. What changes need to be made to ensure that performance levels continue?

10. Is there anything else you want to tell us or ask us?